Arizona Department of Health Services
Division of Behavioral Health Services

Office of Program Support

Operations and Procedures Manual

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Introduction

The Office of Program Support (OPS) is within the Bureau of Financial Operations and provides oversight, coordination and monitoring to the Tribal and Regional Behavioral Health Authorities (T/RBHAs). This document is a reference guide describing the procedural requirements between the T/RBHAs, the Arizona Department of Health Services, Division of Behavioral Health (ADHS/DBHS), Office of Program Support, and the Arizona Health Care Cost Containment System (AHCCCS). The Operations and Procedures Manual is available on the ADHS/DBHS website and is to be used as the first point of reference when procedural questions arise.

Individuals with questions should contact their assigned T/RBHA Representative between the hours of 8:00 A.M. to 5:00 P.M. Monday through Friday.

Definitions

Aged Pended Encounter	An encounter that has pended for more than 120 calendar days, after the initial processing date at AHCCCS, without resolution.
AHCCCS	Arizona Health Care Cost Containment System
AHCCCSA	Arizona Health Care Cost Containment System Administration
AHCCCSA Error	A pended encounter which AHCCCS acknowledges to be the result of its own and has been communicated to the RBHA by way of an edit alert, email, phone conversation, typed letter, Workgroup communication or other forum.
Check Register	A detailed log of all checks written and paid to providers for behavioral health services rendered by a RBHA. The check register should include, but is not limited to, check number, date the check was written, check amount, and provider name and ID.
Client Information System (CIS)	The data system used by ADHS/DBHS.
Contract Year	A period from July 1 of a calendar year through and including June 30 of the following year.
CRN	Claim Reference Number, used to track and review encounters in the PMMIS system at AHCCCS.
Days	A calendar day unless otherwise specified
DBHS	Division of Behavioral Health Services

Definitions

DBHS Error	A pended encounter which DBHS acknowledges to be the result of its own error and has been communicated to the RBHA by way of an edit alert, email, phone conversation, typed letter, Workgroup communication or other forum.
Deleted Encounter	A pended encounter that has been deleted from the PMMIS system at AHCCCS by request from a RBHA because the encounter was sent to DBHS in error or should not have been sent to AHCCCS by DBHS.
Encounter	A record of a covered service rendered by a provider to a person enrolled with a capitated RBHA on the date of service
Enrollment	The process by which a person is enrolled into the Contractor and DHS data system
Fee-For-Service (FFS)	A fee paid for each service based on actual utilization of services, using payment rates set for units of care provided
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to the person or some other person. It includes any act that constitutes fraud under applicable Federal or State Law.
GSA	Geographic Service Area
ICN	Internal control number used in the CIS system
Override (of Encounter)	A process performed by a RBHA to bypass a pend status on an AHCCCS encounter which will allow the encounter to adjudicate cleanly.
Pended Encounter	An encounter that was sent to AHCCCS from DBHS that did not cleanly adjudicate but resulted in an error, known as a “pend”.
Provider	Provider refers to all behavioral health providers under contract with a RBHA or a RBHA network that deliver services to behavioral health clients (any provider that the RBHA will receive a claim/encounter from)
Quarter	Three months of the state fiscal year as broken into four quarters. July 1 through September 30 is referred to as the first quarter of the state fiscal year
Regional Behavioral Health Authority (RBHA)	An organization under contract with the ADHS to coordinate the delivery of behavioral health services to eligible and/or enrolled persons in a geographically specific service area of the state.

Definitions

T/RBHA	A reference to both RBHAs and Tribal RBHAs
Tribal RBHA	A Native American Indian tribe under Intergovernmental Agreement with ADHS to coordinate the delivery of behavioral health services to eligible and enrolled persons who are residents of the Federally recognized Tribal Nation that is the party to the Intergovernmental Agreement.
Voided Encounter	An encounter previously accepted at DBHS or AHCCCS, but was voided by request from a RBHA because the encounter was sent to DBHS in error or should not have been sent to AHCCCS by DBHS.

Related Information Resources

The T/RBHA should use the following resources in addition to this manual:

- Client Information System (CIS) File Layout and Specifications Manual
- ADHS/DBHS Covered Behavioral Health Services Guide
- ADHS/DBHS Demographic User's Guide
- ADHS/DBHS Tidbits Newsletter
- The ADHS/DBHS Contract with each T/RBHA
- AHCCCS Encounter Resources, including
    - Encounter Reporting Manual
    - Medical Policy Manual
    - Encounter Keys and Claims Clues Newsletters
    - Technical Interface Guidelines (TIG)
    - AHCCCS Behavioral Health Services Technical Interface Guidelines
- Coding Documentation
    - UB-92 Manual/UB-04 Manual
    - ICD-9-CM Diagnosis & Procedure Code Manual
    - Physician's Current Procedural Terminology (CPT) Manual
    - HCFA Common Procedures Coding System (HCPCS) Manual
    - First Data Bank Blue Book
    - Client Information System (CIS File Layout and Specifications Manual)
    - HIPAA Guidelines via www.cms.hhs.gov/HIPAAGenInfo

Provider Registration

Introduction:

All providers are required to register with the AHCCCS Administration and obtain an AHCCCS provider identification number.

Providers are required to:

- Complete an application
- Sign a provider agreement
- Sign all applicable forms, and
- Submit documentation of their applicable licenses and/or certificates

Information may be obtained by calling the AHCCCS Provider Registration Unit at:

Phoenix area: (602) 417-7670 (Option 5)
In-state: 1-800-794-6862 (Option 5)
Out of state: 1-800-523-0231, Ext. 77670

AHCCCS Provider Registration materials are available on the AHCCCS Web site at www.ahcccs.state.az.us .

National Provider Identifier (NPI)

Effective January 23, 2004, the final rule regarding the National Provider Identifier (NPI) was published. CMS started assigning NPI numbers to providers last May, and beginning in May 2007 NPIs are required. Providers can apply for an NPI online at https://nppes.cms.hhs.gov or can call the NPI enumerator to request a paper application at 1-800-465-3203.

Health Care Providers *must* communicate their National Provider Identifier's [NPIs] directly to the AHCCCS Administration,

The following outlines 3 Options for getting the required NPI information to the AHCCCS Administration.

Option 1: An electronic mailbox has been established for providers to forward a copy of their NPI notification via email. This email address can only accept copies of the statement emailed to the provider from the NPI enumerator. Please note that the Provider AHCCCS ID number also needs to be included in the email for identification purposes. This email address is NationalProviderID@azahcccs.gov.

Option 2: Providers may submit a copy of the NPI notification received from the NPI enumerator, either via mail or fax. Again, the provider's name and AHCCCS ID number need to be included on the document. The information should be mailed or faxed to:

AHCCCS
Provider Registration Unit
P.O. Box 25520
Phoenix, AZ 85002
Mail Drop 8100
FAX: (602) 256-1474

Option 3: NPI numbers will also be accepted via written notification. Notification must include the provider's name, AHCCCS ID number, NPI number and signature of the provider or an authorized signor.

Intake Monitoring

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Demographic Monitoring

Introduction:

RBHAs are required to maintain a demographic acceptance rate of 90% or greater. Acceptance rates are significant as they may be the first indication of possible systemic problems. The OPS monitors demographic acceptance rates daily. Information necessary to submit complete and accurate demographics can be found at http://www.azdhs.gov/bhs/provider/ddsug.pdf . In addition, CIS demographic acceptance rates are scored as part of each RBHA's yearly Administrative Review.

Daily Demographic Acceptance Reports:

RBHAs place daily demographic files on the FTP server to be processed. The files are processed through the new day batch process on a nightly basis by the ADHS/DBHS IT department. Demographic acceptance rates are calculated by the IT Department based on the number of rejected encounters versus the number of accepted encounters. When a RBHA Representative needs to acquire a Demographic Acceptance report the "Demographics" database will build a query and send the request directly to CIS, which will return the data back to the database for review. There are no files that need to be imported for this process.

Reviewing Daily Demographic Acceptance Reports:

The RBHA Representatives are required to review the RBHA's acceptance rates on a daily basis using the Daily Detail Demographic Acceptance Report (Attachment 1). The steps to be performed are as follows:

1. Open the "Demographics" database by double-clicking on the desktop shortcut. If the shortcut is not available, go to the following target location: M:\Program Support Staff\Demographics_database, then double-click on the Demographics.mdb file.
2. Select "Daily Detail Report" from the Demographics Main Switchboard screen.
3. When the Criteria Selection Form appears, click on the "Report:" drop-down dialogue box and select "Daily Detail Demographic Report".
4. Enter a Start Date: in the format MM/DD/YYYY
5. Enter an End Date: in the format MM/DD/YYYY
6. Use the "RBHA" drop down dialogue box to select the RBHA number of which the report should reflect.
7. Enter Notes in the "Notes" text box when applicable. To view notes at any time, check the "Collect all notes" box. Once notes are entered for a specific date, the notes will always be in the database.
8. Click on "Print". The report will appear and is broken down by date.
9. Print the report by clicking on the "File" menu and selecting "Print". Store the printout in a three ring binder specific to the RBHA.

Analyzing Data:

RBHA Representatives will examine their RBHA's demographic submissions to ensure a minimum 90% acceptance rate is achieved. For any demographic submission that does not meet the 90% acceptance rate threshold, an explanation of the cause(s) is/are mandatory from the RBHA.

RBHA Documentation:

RBHAs are required to provide ADHS/DBHS an explanation within 2 business days, when acceptance rates fall below the 90% minimum. RBHA representatives will maintain this documentation by adding the explanations in text to the Daily Demographic Acceptance Report database. ADHS/DBHS will consider systemic problems when analyzing the demographic acceptance rates.

Results:

If a 90% minimum acceptance rate is not maintained during the period of a quarter, a letter is sent to the RBHAs CFO before the end of the quarter notifying them that they could be placed in the testing environment (See Test Criteria section of this manual). If the RBHA continues to average below 90% acceptance rates through the remainder of the quarter, the RBHA will be placed in the test environment at the end of the quarter. See Submission Test Criteria Section.

Administrative Review Scoring:

RBHA Demographic acceptance rates are monitored as part of the RBHA's yearly Administrative Review. Complete information regarding the scoring of Administrative Review standards can be found in the Administrative Review Section of this manual.

Attachment 1

Demographic Acceptance Report

Arizona Department of Health Services/Division of Behavioral Health Services

Daily Detail Demographic Acceptance Report -

1/1/2007 - 3/31/2007

Process	Total	Detail	Accepte	Rejecte	%
2/6/2007	14,232	14,231	13,363	868	93.90
2/7/2007	14,232	14,231	13,364	867	93.91
2/8/2007	4,872	4,871	4,129	742	84.77
2/8/2007	4,872	4,871	4,124	747	84.66
2/12/2007	1,064	1,063	929	134	87.39
2/13/2007	1,044	1,043	979	64	93.86
2/14/2007	243	242	233	9	96.28
2/14/2007	621	620	571	49	92.10
2/15/2007	386	385	365	20	94.81
2/16/2007	508	507	473	34	93.29
2/20/2007	436	435	367	68	84.37
2/21/2007	406	405	351	54	86.67
2/22/2007	330	329	272	57	82.67
2/23/2007	509	508	456	52	89.76
2/27/2007	714	713	617	96	86.54
2/28/2007	334	333	296	37	88.89
3/1/2007	318	317	279	38	88.01
3/2/2007	404	403	368	35	91.32
3/5/2007	242	241	202	39	83.82
3/6/2007	376	375	341	34	90.93
3/7/2007	220	219	194	25	88.58
3/8/2007	462	461	425	36	92.19
3/9/2007	202	201	192	9	95.52
3/12/2007	166	165	157	8	95.15
3/13/2007	251	250	215	35	86.00
3/14/2007	318	317	301	16	94.95
3/15/2007	269	268	255	13	95.15
3/16/2007	315	314	286	28	91.08
3/19/2007	275	274	257	17	93.80
3/20/2007	222	221	209	12	94.57
3/21/2007	428	427	392	35	91.80
3/22/2007	382	381	358	23	93.96
3/23/2007	315	314	290	24	92.36
3/26/2007	281	280	260	20	92.86
3/27/2007	256	255	243	12	95.29
3/28/2007	241	240	218	22	90.83
3/29/2007	200	199	185	14	92.96
3/30/2007	184	183	167	16	91.26
Grand Total	51,130	51,092	46,683	4,409	91.37%

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Closure Monitoring

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Submission Schedules

Introduction:

The Office of Program Support (OPS) requires all RBHAs to establish and adhere to a Submission Schedule when submitting encounters to ADHS/DBHS for each of the three form types (HCFA, UB or Drug). In addition encounter submissions will be monitored for volume consistency. The Submission Schedule and encounter volume are monitored and scored as part of each RBHA's yearly Administrative Review.

Setting a Submission Schedule:

A new RBHA has 90 days to select a set Submission Schedule that they must adhere to upon completion of their initial encounter testing with ADHS/DBHS. For all RBHAs, the HCFA encounter files must be submitted at least bi-monthly, where as UB and Drug encounter files may be submitted according to any of the three following schedules:

- **Monthly** – The RBHA must submit at least one encounter file for a specific form type, per GSA if applicable, in the period of one month.
- **Bi-monthly** – The RBHA must submit at least one encounter file for a specific form type, per GSA if applicable, every two weeks.
- **Weekly** – The RBHA must submit at least one encounter file for a specific form type, per GSA if applicable, every week.

Monitoring:

RBHA Representatives will monitor their respective RBHA's encounter submissions using the "Daily enc submission rpt" (attachment 1) and will include the results in the RBHAs Workgroup agenda for discussion. RBHA Representatives are to follow the procedures listed in the CIS Encounter Acceptance Rates Policy to produce the report.

Test Environment:

A RBHA may be placed into the testing environment if it fails to adhere to the established Submission Schedule for any form type during the period of one quarter. Complete information regarding being placed in "Test" can be found in the Test Criteria Section of this manual.

Administrative Review Scoring:

RBHA Submission Schedules are monitored as part of the RBHA's yearly Administrative Review. Complete information regarding the scoring of Administrative Review standards can be found in the Administrative Review Section of this manual.

Attachment 1

Daily Detailed Encounter Acceptance Report

Daily Detail Encounter

Arizona Department of Health Services/Division of Behavioral Health Services

Daily Detail Encounter Acceptance Report - GSA - 1/1/2007 - 3/31/2007

	Process Date	Total Enc.	Processed Enc.	Voids	Void %	Accepted	Rejected	% Accepted
DRUG								
	1/3/2007	13,211	13,211	0	0.00%	12,945	266	97.99%
	1/25/2007	13,238	13,238	0	0.00%	13,013	225	98.30%
	2/22/2007	14,936	14,936	0	0.00%	14,187	749	94.99%
	3/29/2007	12,223	12,223	0	0.00%	12,019	204	98.33%
Total		53,608	53,608	0		52,164	1,444	97.31%
HCFA								
	1/2/2007	136	0	136	100.00%	26	110	19.12%
	1/5/2007	25,767	25,510	257	1.00%	25,452	317	98.78%
	1/12/2007	12,411	12,407	4	0.03%	12,263	162	98.81%
	1/22/2007	19,986	19,986	0	0.00%	19,787	201	99.00%
	1/25/2007	13,612	13,612	0	0.00%	13,314	298	97.81%
	1/31/2007	13,215	13,215	0	0.00%	12,928	292	97.83%
	2/1/2007	310	310	0	0.00%	181	129	58.39%
	2/8/2007	16,433	16,115	318	1.94%	16,326	107	99.35%
	2/15/2007	17,650	17,343	307	1.74%	17,372	278	98.42%
	2/22/2007	24,170	24,170	0	0.00%	24,073	97	99.60%
	3/6/2007	17,968	17,967	1	0.01%	17,710	258	98.56%
	3/9/2007	13,618	13,598	20	0.15%	13,516	102	99.25%
	3/12/2007	363	362	1	0.28%	352	11	96.97%
	3/13/2007	16,217	16,217	0	0.00%	16,165	52	99.68%
	3/14/2007	318	318	0	0.00%	318	0	100.00%
	3/23/2007	16,440	15,366	1,074	6.53%	16,368	72	99.56%
	3/27/2007	669	628	41	6.13%	633	36	94.62%
	3/28/2007	17,569	16,420	1,149	6.54%	15,635	1,941	88.99%
Total		226,852	223,544	3,308		222,419	4,466	98.04%
UB								
	1/24/2007	800	800	0	0.00%	768	32	96.00%
	2/28/2007	267	267	0	0.00%	240	27	89.89%
	3/8/2007	3	0	3	100.00%	3	0	100.00%
	3/27/2007	315	315	0	0.00%	285	30	90.48%
	3/28/2007	16	16	0	0.00%	14	2	87.50%
Total		1,401	1,398	3		1,310	91	93.50%
Grand Total		281,861	278,550	3,311		275,893	6,001	97.88%

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CIS Encounter Acceptance Rate

Introduction:

RBHAs are required to maintain an encounter acceptance rate of 90% or greater. Acceptance rates are significant as they may be the first indication of possible systemic problems. The OPS monitors encounter acceptance rates daily. In addition, CIS encounter acceptance rates are scored as part of each RBHA's yearly Administrative Review.

Importing Daily Encounter Acceptance Reports:

RBHAs place daily encounter files on the FTP server to be processed. The files are processed through the new day batch process on a nightly basis by the ADHS/DBHS IT department. CIS encounter acceptance rates are calculated by the IT Department based on the number of rejected encounters versus the number of accepted encounters. IT then places a text file containing all of the encounter acceptance data into the M:\Common\Program Support directory and in turn notifies OPS by email when completed. A designated OPS RBHA Representative imports the text file into the departments' established MS Access database. The RBHA Representative then notifies the other RBHA Representatives via email that the Daily Encounter Reports for a specific date have been imported to the MS Access database.

Reviewing Daily Encounter Acceptance Reports:

The RBHA Representatives are required to review the RBHA's acceptance rates on a daily basis using the Daily Detail Encounter Acceptance Report (Attachment 1). The following are the steps to be performed:

1. Open the "Daily enc submission rpt" database by double-clicking on the desktop shortcut. If the shortcut is not available, go to the following target location: M:\Program Support Staff\Daily_encounters_database, then double-click on the Daily enc submission rpt_db.mdb file.
2. Select "Reports" from the Daily Encounters Main Switchboard screen.
3. When the Criteria Selection Form appears, click on the "Report: " drop-down dialogue box and select "Daily Detail Encounter Acceptance Report".
4. Enter a Start Date: in the format MM/DD/YYYY.
5. Enter an End Date: in the format MM/DD/YYYY.
6. Use the "RBHA" drop down dialogue box to select the RBHA number of which the report should reflect.
7. Enter Notes in the "Notes" text box when applicable. To view notes at any time, check the "Collect all notes" box. Once notes are entered for a specific date, the notes will always be in the database.
8. Click on "Print". The report will appear and is broken down by form type.
9. Print the report by clicking on the "File" menu and selecting "Print". Store the printout in a three ring binder specific to the RBHA.

Analyzing Data:

RBHA Representatives will examine their RBHA's encounter submissions to ensure a minimum 90% acceptance rate is achieved for each encounter form type. For any encounter form type that does not meet the 90% acceptance rate threshold, an explanation of the cause(s) is/are mandatory from the RBHA.

RBHA Documentation:

RBHAs are required to provide ADHS/DBHS an explanation within 2 business days, when acceptance rates fall below the 90% minimum. RBHA representatives will maintain this documentation by adding the explanations to the Daily Encounter Acceptance Report database. ADHS/DBHS will consider systemic problems when analyzing the encounter acceptance rates.

Results:

If 90% minimum acceptance rates are not maintained for any one form type during the period of a quarter, a letter is sent to the RBHAs CFO before the end of the quarter notifying them that they could be placed in the testing environment (See Test Criteria Section of this manual). If the RBHA continues to average below 90% acceptance rates through the remainder of the quarter, the RBHA will be placed in the test environment at the end of the quarter. See Submission Test Criteria Section.

Administrative Review Scoring:

RBHA Acceptance rates are monitored as part of the RBHA's yearly Administrative Review. Complete information regarding the scoring of Administrative Review standards can be found in the Administrative Review Section of this manual.

Attachment 1

Daily Detail Encounter Acceptance Report

Arizona Department of Health Services/Division of Behavioral Health Services — Daily Detail Encounter

Daily Detail Encounter Acceptance Report - GSA - 1/1/2007 - 3/31/2007

	Process Date	Total Enc.	Processed Enc.	Voids	Void %	Accepted	Rejected	% Accepted
DRUG								
	1/3/2007	13,211	13,211	0	0.00%	12,945	266	97.99%
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	3/8/2007	3	0	3	100.00%	3	0	100.00%
	3/27/2007	315	315	0	0.00%	285	30	90.48%
	3/28/2007	16	16	0	0.00%	14	2	87.50%
Total		1,401	1,398	3		1,310	91	93.50%
Grand Total		281,861	278,550	3,311		275,893	6,001	97.88%

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Test Criteria

Introduction:

There are several scenarios that may require a RBHA to submit data into the CIS test environment rather than directly into production.

Conditions for placing a RBHA into the testing environment:

- A new contract has been awarded to a Regional Behavioral Health Authority. All transactions including but not limited to:
    - 837P (Professional Encounter)
    - 837I (Institutional Encounter)
    - NCPDP (Drug Encounter)
- System modifications have been implemented in CIS i.e. "Covered Services and HIPAA" or as requested by OPS.
- The RBHA fails to maintain an average 90% or greater acceptance rate on any form type for a period of one quarter
- The RBHA fails to adhere to the established submission schedule for any form type for a period of one quarter.
- Submission volumes drop 50% from the number of records submitted during the previous quarter compared with the most recent quarter completed, for any form type.
- Upon removal from the testing environment due to satisfactory completion of the test criteria, a RBHA may be moved back into test if any one of the first three submissions to production does not meet the 90% acceptance threshold. The RBHA will then have to achieve a 90% or greater acceptance rate on a minimum of 3 additional test files, for each form affected, before being placed back into the production environment.

Monitoring:

The RBHA Representatives are responsible for monitoring all aspects of the RBHA' encounter submissions. If any of the above conditions are met the RBHA Representative will send the preliminary warning letter to the RBHA (attachment 1). The RBHA Representative will continue to monitor the RBHA, if conditions exist at the end of the quarter a letter will be sent to the RBHA to advise that the RBHA has been placed in Test (attachment 2). The RBHA Representative will continue to monitor the RBHA to determine when the RBHA can be moved back to production.

Testing Environment:

The RBHA Representative will work closely with any RBHA that has been placed in the testing environment to ensure test files are submitted appropriately during special day runs and to offer assistance when system problems are identified. RBHAs must continue to adhere to their agreed upon submission schedule while in the Test Environment. For the encounter form type(s) that

have been restricted to the test environment, special day runs will be the only form of submission until the test criteria has been satisfactorily met. Special day run requests are to be sent by email to the respective RBHA Representative at least a day in advance of the scheduled test, and encounter test files are to be received by 10:00AM the day of the test run so DBHS ITS has time to prepare the appropriate resources. Upon completion of special day runs, results will be placed on the FTP server and a RBHA representative will immediately notify the RBHA by email.

OPS and/or IT may allow additional test run times/days for special implementations. The RBHA will be notified if this circumstance occurs.

Production Environment:

In order to move from the testing environment to production the following criteria must be met. This applies to conditions referenced in the previous section.

- The testing transaction must be an original transaction. An original transaction is defined as having not been included on a previous test or production file
- The test file must represent an average days worth of data with a minimum of 25 transactions. OPS will determine file size expectations by evaluating the submission volume history for the RBHA
- A test file submitted by the RBHA certifies the data transactions have been generated by the RBHAs internal system and have not been altered in any manner, i.e., manually manipulated, manually generated or generated from a like, or any other system.
- The RBHA must have basic edits in place to ensure cleaner encounter submissions to DBHS. The basic edits are to match the pre-processor edits of DBHS. These edits include, and are not limited to, eligibility, provider, duplicate, the B5 matrix and billing limitations.
- The RBHA must achieve a 90% or greater acceptance rate on a minimum of 5 test files for each form type affected.
- The RBHA must submit in writing an attestation to DBHS that system deficiencies have been corrected per the above.

Attachment 1

Encounter Submission Initial Testing Criteria Letter Template

[Date]

[Recipient]
[RBHA or Agency]
[Address]
[City, State Zip]

Dear [Dr./Mr./Ms.] [Recipient],

The Office of Program Support (OPS) monitors RBHA submissions and acceptance rates in the CIS system daily. [RBHA] has had an acceptance rate lower than 90% for [form type] during the quarter of [enter quarter months]. If [RBHA] continues to average below 90% acceptance rates through the remainder of the quarter [RBHA] will be placed in the test environment at the end of the quarter. [RBHA] must then correct their system and adhere to the following conditions to return to the production environment.

Conditions that must be met prior to satisfactorily completing testing:

- The testing transaction must be an original transaction. An original transaction is defined as having not been included on a previous test or production file
- The test file must represent an average days worth of data with a minimum of 25 transactions. OPS will determine file size expectations by evaluating the submission volume history for the RBHA
- A test file submitted by the RBHA certifies the data transactions have been generated by the RBHAs internal system and have not been altered in any manner, i.e., manually manipulated, manually generated or generated from a like, or any other system.
- The RBHA must have basic edits in place to ensure cleaner encounter submissions to DBHS. The basic edits are to match the pre-processor edits of DBHS. These edits include, and are not limited to, eligibility, provider, duplicate, the B5 matrix and billing limitations.
- The RBHA must achieve a 90% or greater acceptance rate on a minimum of 5 test files for each form type affected.
- The RBHA must submit in writing an attestation to DBHS that system deficiencies have been corrected per the above.

If the RBHA experiences technical difficulties within their system that are unable to be corrected internally, the RBHA should contact their assigned RBHA Representative for assistance.

Thank you for your attention to this matter. Please feel free to contact me at 602-364-4727 should you have any questions.

Sincerely,

[Name]
Eligibility/Encounter Manager

Enclosures

c: [OPS Manager], ADHS/DBHS
OPS RBHA Representatives
[IT Manager], ADHS/DBHS
Contract Compliance File

Attachment 2

Encounter Submission Final Testing Criteria Letter Template

[Date]

[Recipient]
[RBHA or Agency]
[Address]
[City, State Zip]

Dear [Dr./Mr./Ms.] [Recipient],

The Office of Program Support (OPS) monitors RBHA submissions and acceptance rates in the CIS system daily. As advised in the letter dated [insert date of first letter] [RBHA] has had an acceptance rate lower than 90% for [form type] for the quarter of [enter quarter months]. [RBHA] will be placed in the test environment effective [insert date]. [RBHA] must correct their system and adhere to the following conditions to return to the production environment.

Conditions that must be met prior to satisfactorily completing testing:

- The testing transaction must be an original transaction. An original transaction is defined as having not been included on a previous test or production file
- The test file must represent an average days worth of data with a minimum of 25 transactions. OPS will determine file size expectations by evaluating the submission volume history for the RBHA
- A test file submitted by the RBHA certifies the data transactions have been generated by the RBHAs internal system and have not been altered in any manner, i.e., manually manipulated, manually generated or generated from a like, or any other system.
- The RBHA must have basic edits in place to ensure cleaner encounter submissions to DBHS. The basic edits are to match the pre-processor edits of DBHS. These edits include, and are not limited to, eligibility, provider, duplicate, the B5 matrix and billing limitations.
- The RBHA must achieve a 90% or greater acceptance rate on a minimum of 5 test files for each form type affected.
- The RBHA must submit in writing an attestation to DBHS that system deficiencies have been corrected per the above.

If the RBHA experiences technical difficulties within their system that are unable to be corrected internally, the RBHA should contact their assigned RBHA Representative for assistance.

Thank you for your attention to this matter. Please feel free to contact me at 602-364-4727 should you have any questions.

Sincerely,

[Name] Eligibility/Encounter Manager

Enclosures

c: [OPS Manager], ADHS/DBHS
OPS RBHA Representatives
[IT Manager], ADHS/DBHS
Contract Compliance File

Submission Timeliness/210 Report

Introduction:

RBHAs are required to submit all encounters to ADHS/DBHS within 210 calendar days from the ending date of service. Failure to submit an encounter within 210 calendar days will result in an untimely encounter and will be scored as part of each RBHA's yearly Administrative Review. In addition, encounters submitted greater than 210 days may result in a timeliness error during the AHCCCS Data Validation study.

Collecting the Data:

The DBHS/IT department produces an encounter file that identifies all encounters submitted greater than 210 days from the end date of service. IT then places the text file containing all of the encounter data into the M:\Common\Program Support directory and notifies OPS by email when the file is ready to import. A designated OPS RBHA Representative imports the text file into the departments' established MS Access database. The RBHA Representative then notifies the other RBHA Representatives via email that the Daily Encounter Reports for a specific date have been imported to the MS Access database.

Accessing the 210 Report:

The following are steps necessary to access the 210 report:

1. Open the "Daily enc submission rpt" database by double-clicking on the desktop shortcut. If the shortcut is not available, go to the following target location: M:\Program Support Staff\Daily_encounters_database, then double-click on the Daily enc submission rpt_db.mdb file.
2. Select "Reports" from the Daily Encounters Main menu.
3. When the Criteria Selection menu appears, click on the "Report:" drop-down dialogue box and select "Over 210 Days Summary Report".
4. Enter a Start Date: in the format MM/DD/YYYY.
5. Enter an End Date: in the format MM/DD/YYYY.
6. Use the "RBHA" drop down dialogue box to select the appropriate RBHA.
7. Enter Notes in the "Notes" text box when applicable. To view notes at any time, check the "Collect all notes" box. Once notes are entered for a specific date, the notes will always be in the database.
8. Click on "Print". The report will appear with separate line for each form type.
9. Print the report by clicking on the "File" menu and selecting "Print".

Reviewing the 210 Report:

The RBHA Representatives are required to review the 210 report to identify issues RBHAs are having submitting timely encounters. The findings of the 210 report are a standard review item

at the monthly RBHA/OPS Workgroup meetings.

RBHAs are required to provide an explanation if:

- More than five percent of their encounters are submitted over 210 days.
- An increase in untimely encounters is noted.

Administrative Review:

Encounters submitted to ADHS/DBHS greater than 210 days from the end date of service are evaluated and scored as part of the yearly Administrative Review. Complete information regarding the scoring of Administrative Review standards can be found in the Administrative Review Section of this manual.

Attachment 1

210 Report

Arizona Department of Health Services/Division of Behavioral Health Services DailyEncounterSummaryR

Greater than 210 days Summary Report - GSA -

1/1/2007 - 3/31/2007

	Total Enc.	Processed Enc.	Voids	Void %	Accepted	Rejected	% Accepted	210 PD	210 %
DBVG	54,030	54,030	0	0.00%	52,586	1,444	97.33%	270	0.51%
HCFA	227,016	223,704	3,312	1.46%	222,580	4,466	98.05%	1,771	0.80%
UB	1,401	1,398	3	0.21%	1,310	91	93.50%	63	4.81%
Grand Total	282,447	279,132	3,315		276,476	6,001		2,104	

% Accepted formula: HCFA/UB Accepted/Approvals 100; DBVG Accepted/Totals 100

Tuesday, May 29, 2007 Page 1 of 1

Aged Pended Encounters/Pend Sanctions

Introduction:

RBHAs must resolve all pended encounters from AHCCCS within 120 calendar days of the original AHCCCS processing date. Failure to resolve AHCCCS pended encounters within 120 days is known as an aged pended encounter and is subject to sanction, with exception to encounters that pended due to AHCCCSA or DBHS error. RBHAs have the ability to work on correcting pended encounters through out the month.

AHCCCS Pended Encounters Cycle:

Monthly AHCCCS sends a file to DBHS containing all encounters that pended, or are still pending at AHCCCS, during that month's adjudication cycle. As soon as DBHS IT receives the file, it is reviewed for errors, placed into manageable file formats and promptly placed on the respective RBHA's FTP server.

1. CIS sends encounter file to AHCCCS
2. AHCCCS returns pends
    a. ITS downloads the report files from the AHCCCS ftp server and notifies OPS when they are available. Get notified by e-mail.
    b. Files are dumped into
        i. M:\systems\rpts\AHCCCS reports\
3. Extract each file from the zip file format and add a .TXT file extension and put in the directory under m:\systems\rpts\AHCCCS reports\convert files\files\IN IN079999. Place files in m:\systems\rpts\AHCCCS reports\convert files\files directory.
4. Use the macro in the AHCCCSre.doc file to convert each file to a word document format. There are 8 text files or health plan. Convert these files in m:\systems\rpts\AHCCCS reports\convert files\files\. Save the files with a ".doc" extension.
   AHCCCSre.doc is in m:\systems\rpts\AHCCCS reports\convert files\AHCCCS report converter\
5. Copy the converted word documents to the program support directory and inform the Encounter staff that they are available.
    a. M:\ program support staff\AHCCCS reports\ HP_079873
    b. Copy file EC9R179.txt to M:\ program support staff\AHCCCS reports\ HP_079873
6. Do not print reports EC97R179-079999 and EC9EM187-079999. Print a copy of the other summary reports and place in the AHCCCS Pended Encounter reporting binder.
7. Back up zip files to the monthly pend archive file located in M:\SYSTEMS\PEND\YYY\file backups\YYYY_MM_files.zip where YYYY and MM is the month and year of the pend cycle.
8. Balance H74ADJREP to AHCCCS EC9CM128 report. See reports marked 1 and 2. H74ADJREP comes from Pat.

9. Balance C1 total to TOTAL from AHCCCS EC9CM187 report (Pended encounters summarized aging report)
10. To process Pend file use ("Kevin run form" along with run date from AHCCCS EC9CM187 report and date imbedded in pend file name)
    a. If importing to an existing db make sure you re-name last months file to prevent it from being overwritten
    b. Kevins run form. M:\SYSTEMS\PEND\YYYY\ master_pendYYYY.mdb
    c. Pend file in M:\systems\rpts looks like e.g. dwn74607.20050205.txt
    d. Creates file PENDED_RECORDS CURR.
    e. Check "Sent to RBHA" flag that it is "Y"
11. Balance C2 and C4 totals to the total pend file record count. If they don't balance inform IT.
12. Use query which converts text fields to numeric data type and strips extra spaces from the text fields and adds comment placeholder.
    a. 2 queries need to be run to do this:
        i. CP175_Apnd_Converted_Comments_Q
        ii. CP175_Apnd_Converted_Data_Q
13. Create new directory under drive "F". F:\RBHA_PENDS\YYYY_MM
14. Export the individual RBHA files and put them in a zipped file in the directory created in step 13. There are 6 queries. Format is "Export_Pend_Data_<RBHA ID>_Q". Export these queries to the F:\RBHA_PEND\YYY_MM directory. Get record counts to give to Javier.
15. Add the exported files to the RBHA zip files out on the F:\RBHA_PEND\YYY_MM drive. The file names are APEND_<RBHA ID>.
16. Open form **ExportReports_FRM**. Press button "Export ALL RBHA Reports". If there are no error messages and the form comes back with "--- DONE ---" then the reports have been created in a new directory on your F drive under the F:\ RBHA_PENDS directory (this directory must exist). E.g. F:\ RBHA_PENDS directory\2006_1 would be for January of 2006.
17. Put the text file and the 2 report files into the appropriate zip file
18. Zip file Password: 2 digits RBHA and "RBHA" and 01. e.g. 03RBHA01
19. Notify Javier that the files are ready with any caveats that may have occurred in the process, like dropped records.
20. Load zip file to RBHA ftp directory
21. Create directory under M"\ Program support staff\RBHA Info\RBHA_PENDS\YYYY_MM
22. Backup all pend files (incoming and outgoing) in monthly zip files.
    a. M:\SYSTEMS\PEND\YYYY\File backups\YYYY_MM_Files.zip.
    b. There is PKZip batch file that is the basis to load the files. M:\SYSTEMS\PEND\Archive_2_zip_list.txt. The file will need to be modified each month to look for the right files.
        i. For a later time the archive process could be automated using the command line arguments. Create a New Archive

To create a new archive, append the file name of the archive to create followed by the list of files to add to the archive. Note, the archive name must end in the .ZIP extension. The archive will be created in the current folder.
pkzipw <archive_name.zip> <list of files to compress, separated with spaces> e.g. pkzipw test.zip file1.doc file2.doc

A RBHA Representative will immediately send an email to all the RBHAs stating that AHCCCS Pend files are available on the FTP server (Attachment 1). This email includes the deadlines of when each step of the pend corrections process is due to DBHS.
RBHAs are to immediately begin working the pends to meet all deadlines. All questions regarding the AHCCCS pended encounters should be directed to the appropriate RBHA Representative.

Monitoring Pended Encounters:

To be proactive in reducing and/or eliminating sanctions due to aging pended encounters, RBHA Representatives will work with RBHAs to address encounters pended more than 90 days. RBHA Representatives shall take the following steps to monitor pended encounters:

1. Access "M:\Program Support Staff\AHCCCS Reports\HP_079999" and locate the Aging Pended Encounters snapshot files for each RBHA, titled, "OPS_Pend_Rpt_Aging_RBHA_XX" (XX being the RBHA identifier). This file is available when the AHCCCS pend files are placed on the FTP server for RBHAs.
2. Print copies of the snapshot file for distribution and discussion at RBHA Workgroup meetings. Make sure to address all pended encounters that have been pending greater than 90 days and have the RBHA explain why the pend error is unresolved.
3. Follow up with the RBHA throughout the month to ensure the RBHA has been able to correct aging pends and/or understand how to correct them.
4. Assure IT has completed SSRs for deletion of pended encounters due to DBHS error.
5. Contact the AHCCCS Technical Assistant Representative to ensure override requests are completed in a timely fashion.

Deleting, Voiding, and Overriding of Encounters:

Pended encounters must not be deleted or voided by a RBHA as a means of avoiding sanctions for failure to correct encounters within 120 days. The RBHA shall document all Title XIX and Title XXI encounters deleted, voided or overridden encounters and maintain a record of CRNs with appropriate reasons indicated. See Deletion/Override Log section of this manual.

Preliminary Sanctioning Process:

AHCCCS on a quarterly basis distributes to DBHS/OPS via the FTP server their preliminary

findings of sanctionable aged pended encounters (Attachment 2). The preliminary findings are divided into aged pended encounters that are excluded from sanction (Attachment 3) and those that are being sanctioned (Attachment 4). A summary of all sanctionable pended encounters are also placed on the FTP server by AHCCCS in the form of an Excel spreadsheet. The Encounter Manager or Supervisor is responsible for moving these files to the "M:\Program Support Staff\Encounters\Pend Sanctions\" folder. The Encounter Manager then provides each RBHA with a letter defining the preliminary results and includes a CD containing the spreadsheet summary of the sanctionable aged pended encounters specific to the RBHA for review and comment (Attachment 5).

Challenge Preliminary Findings:

The RBHA is responsible for identifying any pends that they want to challenge in the preliminary report. Each challenge must be supported by additional documentation. Types of additional documentation include, but are not limited to:

- PMMIS screen prints
- CIS screen prints
- Screen prints from the RBHA's internal system

OPS will review all challenges from the RBHA and determine the documentation that will be forwarded to AHCCCS for consideration of reducing sanctions.

Final Sanction Determination:

Once AHCCCS reviews all challenges and/or additional documentation, a final decision is made as to which pended encounters are sanctionable (Attachment 6). The sanctions are then calculated (Attachment 7) according to age category. Office of Business Operations is notified of the final sanction amounts and funds are withheld from the sanctioned RBHAs capitation payment the following month. DBHS/OPS will send a letter to each RBHA advising them of any final sanction amounts (Attachment 8). Whether sanctions are waived or not, a RBHA is still responsible for correcting all pended encounters unless the error is on behalf of AHCCCSA or DBHS.
Sanctions are imposed according to the following schedule:

0 – 120 days	**121 – 180 days**	**181 – 240 days**	**241 – 360 days**	**361 + days**
No sanction	**$5 per month**	**$10 per month**	**$15 per month**	**$20 per month.**

Administrative Review Scoring:

Aged pended encounters are monitored as part of the RBHA's yearly Administrative Review. Administrative Review standards can be found in the Administrative Review Section of this manual.

Attachment 1

AHCCCS Pends Availability and Correction Due Dates Email

IMPORTANT INFORMATION - December 2006 Pend Data

1) Pend Files are Ready
Your current pend file (APEND_rr.txt) is available on the OPS FTP server in the password protected zip file (APEND_rr.ZIP).
**Please note that your file contains all pended records (hard and soft). Do not work the soft edits.

MONTH	RBHA	RECS	FTP_TO_RBHA
2006-12	02	6,344	Y
2006-12	08	13,127	Y
2006-12	15	842	Y
2006-12	22	575	Y
2006-12	26	3,168	Y
2006-12	27	1,245	Y

2) Pend Reporting
Reports of all encounters pended at AHCCCS for the month of December 2006 have been generated and placed in your respective RBHA directory on the FTP server.

3) Pend Processing Deadlines

A) DelDup File (AHCCCS Pend Overrides, & Subvention Deletions) **Due By: Noon 12/28/2006**
Use only the following combinations of Error and Reason Codes.

Error Code	Reason Code
	A001 Per RBHA review, not a duplicate encounter
R410	D012 Recipient not AHCCCS eligible during dates of service (R410, R480)
R480	D012 Recipient not AHCCCS eligible during dates of service (R410, R480)
R660	D017 Recipient does not have MHS enrollment at AHCCCS during dates of service (R660)
H280	D018 Encounter not eligible to adjust (H280)
N027	D019 Drug not elig for Medicaid coverage (N027)

B) All other error codes should be adjudicated either through on-line correction of applicable data fields in the CIS system, or through submission of a full void transaction in the normal daily process.
All pended encounter on-line corrections and void transactions must be completed in CIS by 11:00 am 1/2/2007.

4) Pend Error Questions
Please feel free to contact your respective OPS RBHA Representative should you have any questions, or should you require any additional information.

Cenpatico (02, 22)
Gary Szymanski
(602) 364-4677
szymang@azdhs.gov

NARBHA (15)
Eunice Argusta
(602) 364-4526
arguste@azdhs.gov

CPSA (26, 27)
Javier Higuera
(602) 364-4715
higuerj@azdhs.gov

ValueOptions (08)
Renee Chavez
(602) 364-4734
chavezr@azdhs.gov

Attachment 2

Preliminary Sanction Summary

Preliminary Sanction Summary

Quarter Ending: June, 2006

Plan ID: 079999 **Plan Name:** ADHSBHS

TSN: 79

Age Category	Total Encounters	Sanction Amount
181-240 Days	2	$20
241-360 Days	4	$60

TSN: 80

Age Category	Total Encounters	Sanction Amount
121-180 Days	1	$5
241-360 Days	4	$60

TSN: 81

Age Category	Total Encounters	Sanction Amount
121-180 Days	4	$20
181-240 Days	3	$30

TSN: 84

Age Category	Total Encounters	Sanction Amount
121-180 Days	1	$5

Plan Total	Total Encounters	Sanction Amount
	19	$200

Tuesday, August 01, 2006 Page 1

Attachment 3

Pended Encounters Excluded from Preliminary Sanctions

Summary of Encounters Excluded From Preliminary Sanctions

Quarter Ending: *June, 2006*

Plan ID: *079999* ***Plan Name:*** *ADHSBHS*

Error Code	*Error Description*	*Form Type*	*TSN*	*Total*
A951	FORCE PEND FOR CONTRACTOR CORRECTIONS	A	79	6
A951	FORCE PEND FOR CONTRACTOR CORRECTIONS	A	80	90
A951	FORCE PEND FOR CONTRACTOR CORRECTIONS	I	93	12
A951	FORCE PEND FOR CONTRACTOR CORRECTIONS	I	79	28
P210	IHS SERVICE PROVIDERS ARE FEE FOR SERVICE ONLY	A	81	78
P210	IHS SERVICE PROVIDERS ARE FEE FOR SERVICE ONLY	A	80	295
P340	PROVIDER SPECIFIC RATE NOT ON FILE FOR DOS	I	79	2
P340	PROVIDER SPECIFIC RATE NOT ON FILE FOR DOS	I	93	3
P353	RATE NOT FOUND ON PROV TYP TBL	I	79	6
R410	RECIPIENT NOT ELIGIBLE FOR AHCCCS SERVICES ON SERVICE DATES	A	80	1
R480	RECIPIENT NOT ENROLLED ON SERVICE DATES	C	81	6
R600	MEDICARE COVERAGE INDICATED BUT NOT BILLED	A	81	12
R600	MEDICARE COVERAGE INDICATED BUT NOT BILLED	A	83	36
R632	MEDICARE APPROVED AND PAID NOT BOTH PRESENT	A	83	2
V151	OR RM BILL-ICD9 AND/OR HCPCS MUST = SURGICAL	I	79	6
V152	OR RM BILL-NO SURG ICD9 AND/OR HCPCS CODE PRESENT	I	79	3
Z610	EXACT DUPLICATE FOUND	I	79	6
Z615	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	I	80	1
Z615	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	I	79	6
Z620	NEAR DUPLICATE FOUND	I	93	2
Z720	EXACT DUPLICATE FOUND	A	81	4
Z720	EXACT DUPLICATE FOUND	A	83	8
Z720	EXACT DUPLICATE FOUND	A	79	12
Z725	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	A	83	1
Z725	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	A	79	58
Z725	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	A	93	210
Z725	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	A	80	272
Z745	NEAR DUPLICATE FROM DIFFERENT HEALTH PLANS	A	80	3
Z745	NEAR DUPLICATE FROM DIFFERENT HEALTH PLANS	A	93	12
Z760	NEAR DUPLICATE FOUND - FROM-THROUGH DATES OVERLAP	A	81	1
Z805	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	C	94	8
Z805	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	C	84	47
Z805	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	C	83	129
Z805	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	C	93	352
Z805	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	C	79	510
Z805	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	C	80	6,505
Plan Total				8,733

Thursday, July 27, 2006 *Page 1*

Attachment 4

Preliminary Encounter Sanctions Error Summary

Preliminary Encounter Sanctions Error Summary

Quarter Ending: *June, 2006*

Plan ID: *079999* ***Plan Name:*** *ADHSBHS*

Error Code	*Error Description*	*Form Type*	*Total*
D010	PRIMARY DIAGNOSIS NOT ON FILE (FOR DOS)	A	1
D305	INAPPROPRIATE DIAGNOSIS SEQUENCE	A	1
D305	INAPPROPRIATE DIAGNOSIS SEQUENCE	A	1
N004	NDC CODE NOT ON FILE	C	1
N004	NDC CODE NOT ON FILE	C	5
R660	DHS MHS ENC RCP MUST BE ON MHS ENROLL	A	4
T005	PSYCH BED W/OUT PSYCH DX-INVALID	I	1
V020	REVENUE CODE NOT ON FILE FOR DOS	I	1
V045	NO ACCOMMODATION BILLING - BILL IS I/P OR LTC	I	4
Plan Total			19

Thursday, July 27, 2006 *Page 1*

Attachment 5

Preliminary Sanction Letter Sent to RBHAs

[Date]

[Recipient]
[RBHA]
[Address]
[City, State Zip]

Dear [Dr./Mr. or Ms.] [Recipient]:

The purpose of this letter is to inform you of the preliminary results of sanctionable pended encounters for the quarter ending [month, year]. According to your contract, [RBHA] is required to resolve all pended encounters within 120 calendar days of the original processing date.

Enclosed is a diskette with a spreadsheet and the summary reports of your sanctionable pended encounters for the quarter ending [month, year] including preliminary sanction amounts. Please enter your responses to any items believed not to be sanctionable into the designated area of the spreadsheet. Return the diskette and any supporting documentation to the Office of Program Support Encounter Unit, attention Kevin Gibson. If we do not hear from you by [Month Day, Year], we will use the preliminary results as the final sanction amount. The Arizona Department of Health Services/Department of Behavioral Health Services' Encounter Unit will evaluate and, if appropriate, submit a challenge to AHCCCS for final review.

Should you have any questions regarding this matter, please feel free to contact me at (602) 364-4727.

Sincerely,

[Name], Eligibility/Encounter Manager
Bureau of Financial Operations

Enclosures

c: [Name], Deputy Director, ADHS/DBHS
[Name], Chief Financial Officer, ADHS/DBHS
[Name], Program Support Manager, ADHS/DBHS
Contract Compliance File

Attachment 6

Error Summary Final

Error Summary Final

Quarter Ending: *June, 2006*

Plan ID: *079999* ***Plan Name:*** *ADHS/BHS*

Error Code	*Error Description*	*Form Type*	*Total*
D010	PRIMARY DIAGNOSIS NOT ON FILE (FOR DOS)	A	1
D305	INAPPROPRIATE DIAGNOSIS SEQUENCE	A	2
N004	NDC CODE NOT ON FILE	C	6
R660	DHS MHS ENC RCP MUST BE ON MHS ENROLL	A	2
T005	PSYCH BED W/OUT PSYCH DX-INVALID	I	1
Plan Total			12

Wednesday, November 01, 2006 *Page 1*

Attachment 7

Final Sanction Summary

Final Sanction Summary Quarter Ending: June, 2006

Plan ID: **079999** **Plan Name:** **ADHS/BHS**

TSN: 79

Age Category	Total Encounters	Sanction Amount
181-240 Days	1	$10

TSN: 80

Age Category	Total Encounters	Sanction Amount
121-180 Days	1	$5
241-360 Days	2	$30

TSN: 81

Age Category	Total Encounters	Sanction Amount
121-180 Days	4	$20
181-240 Days	3	$30

TSN: 84

Age Category	Total Encounters	Sanction Amount
121-180 Days	1	$5

Plan Total	Total Encounters	Sanction Amount
	12	$100

Wednesday, November 01, 2006 Page 1

Attachment 8

Final Sanction Letter Sent to RBHAs

[Date]

[Recipient]
[RBHA]
[Address]
[City, State Zip]

Dear [Dr./Mr./Ms.] [Name]:

The purpose of this letter is to inform you of the final results of sanctionable pended encounters for the quarter ending [Month, Year].

In a letter dated [Month Day, Year], [RBHA] was provided an opportunity to review the preliminary results, and provide input to items believed to be sanctioned in error. AHCCCS has completed their review of the errors [Enter amount of sanction or amount waived] for all aged pended encounters for this quarter.

Please note that, when sanctions are waived, the RBHA is still liable for correcting all pended encounters unless the error is due to an AHCCCS error.

Should you have any questions regarding this matter, please contact [Name], Encounter Unit Manager at (602) [phone number].

Sincerely,

[Name]
Chief Financial Officer

c: [Name], Deputy Director, ADHS/DBHS
[Name], Program Support Manager, ADHS/DBHS
Contract Compliance File, ADHS/DBHS
RBHA Representatives, ADHS/DBHS

Deletion/Override Log

Introduction:

DBHS/OPS requires each RBHA to maintain and submit a quarterly reconciliation log of all encounters that have been overridden, deleted, or voided from the AHCCCS PMMIS system. The quarterly Deletion and Override logs are scored as part of each RBHA's yearly Administrative Review.

Deletion and Override Log Contents:

The RBHAs are required to maintain a log of all deleted, overridden, or voided encounters from the AHCCCS PMMIS system. The quarterly logs must be submitted in accordance with the following schedule.

Submitting Deletion and Override Logs:

The RBHA is required to submit the Deletion/Override log to OPS no later than the 30th of the month following the end of the quarter. For example, for quarter ending March 31, 2007, the report is due by April 30, 2007. One week prior to the end of each quarter the RBHA Representatives will send an email to each RBHA stating that the Deletion and Override log is due to OPS. If the 30th of the month falls on a holiday or weekend, the RBHA Representative will advise the RBHA of any extension. The RBHA will submit the Deletion and Override log file to the FTP server according to the required Deletion and Override Logs File Layout (Attachment 1). The RBHA will send an email to their RBHA Representative and will copy the Encounter Supervisor when the logs have been placed on the FTP server. Once the RBHA Representative receives the email from the RBHA stating that the Deletion and Override log is available, it will be reviewed for accuracy.

Quarterly Deletion/Override Log Submission Schedule

Review Quarter	Due Date At ADHS/OPS
Ending March 31	April 15
Ending June 30	July 15
Ending September 30	October 15
Ending December 31	January 15

Comparing Deletion and Override Logs for Accuracy:

ADHS/DBHS IT Department keeps a file of each RBHA's voided or deleted encounters and will add in all override requests. This file is made available to the Office of Program Support to compare to the RBHA's submitted log. The system will compare each encounter in the ADHS/DBHS/IT file to the Deletion/Override log submitted by the RBHA. The system will use the following criteria to compare the logs.

- **ICN/Line Number/CRN**: The RBHAS ICN, line number and CRN must match the ADHS/DBHS Deletion and Override file's ICN, line number and CRN for each encounter.
- **Provider ID**: The Provider ID must match the record's Provider ID for each encounter if applicable. The identification number provided must match the original submission.
- **NPI**: The National Provider Identifier must match the record's National Provider Identifier for each encounter. The identification number provided must match the original submission
- **Start/End Date**: The start date and end date must match the records start and end date for each encounter.
- **Error 1**: If the encounter originally pended at AHCCCS, the error should be reported and must match the record's Pended Encounter History Error 1 record for each encounter.
- **Client ID**: The Client ID must match the record's Client ID for each encounter.
- **Reason Code**: If there was a Reason Code submitted for the deletion or override of an encounter from AHCCCS, it must appear in the log and must match the record for each deleted encounter. RBHAs must use one of the OPS approved reason codes. (Attachment 2)
- **Record Missing**: If a RBHA's Deletion and Override log is missing encounter records, as compared to the ADHS/DBHS Deletion and Override file, the number of missing records will be calculated.

Findings:

Upon completion of a RBHA's Deletion and Override log review, the results will be provided to the RBHA Representative. An e-mail will then be sent to the RBHA, by the assigned representative, identifying any errors that have been discovered as well as a final score for that quarter's Deletion and Override log.

Administrative Review Scoring:

RBHA submissions of Deletion/Override Logs are monitored as part of the RBHA's yearly Administrative Review. Complete information regarding the scoring of Administrative Review standards can be found in the Administrative Review Section of this manual.

Attachment 1

Deletion and Override Log

File Name: Enc_Recon_log MMDDYYY_RBHA_ID
Format: comma quote delimited file

Claims and Encounters
Deletion and Override Log
Record Layout

Field Name	Type	*Remarks*
CRN	X(14)	
ICN Number	X(11)	
Line Number	X(2)	
Procedure NDC Revenue Code	X(11)	
Units	Number (7,1)	
RBHA ID	X(2)	
Provider ID Number	X(6)	Must match original submission
National Provider Identifier (NPI)	X(10)	Must match original submission
Service Begin Date	DATE	MM/DD/YYYY
Service End Date	DATE	MM/DD/YYYY
Error Code 1	X(4)	
Error Code 2	X(4)	
Error Code 3	X(4)	
Error Code 4	X(4)	
Type	X(1)	V = Void Transaction
		D = Pend Delete
		O = Pend Override
Client ID	X(10)	
AHCCCS ID	X(9)	
Form Type	X(1)	A-HCFA, B-UB, C-DRUG
Deletion Override Reason	X(4)	
Deletion Override Description	X(200)	

RBHAs must maintain a log containing the fields listed above for every encounter that is deleted, voided or overridden from the PMMIS system at AHCCCS.

Attachment 2

Approved Override Code:

A001	Per RBHA review, not a duplicate encounter

Approved Deletion Codes:

D012	Recipient not AHCCCS eligible/enrolled during dates of service (R410, R480)
D017	Recipient does not have MHS enrollment at AHCCCS during dates of service (R660)
D018	Encounter not eligible to adjust (H280)
D019	Drug not eligible for Medicaid coverage (N027)
DITS	Per RBHAs request deleted by ITS
DOPS	Per RBHA request deleted by OPS

Check Register Review

Introduction:

OPS requires all RBHAs to submit check registers for all Fee-For-Service (FFS) paid claims on a quarterly basis to ensure a RBHA is submitting timely and accurate encounter data. Check register reviews are scored as part of each RBHA's yearly Administrative Review.

Check Register Request:

On a quarterly basis, OPS RBHA Representatives send a request to each RBHA via email stating that the RBHA's check register from the previously ended quarter is due to ADHS/DBHS (Attachment 1). The RBHA is given 10 business days from the date of the email to submit their check register.

Timeframes to be followed:

- The 1st business day of the month the RBHA Representative will send an email to each RBHA requesting the check register for the appropriate fiscal year quarter.
- The RBHA will be given 10 business days to return the check register to their respective RBHA Representative.
- Within 5 business days, the RBHA Representative will submit a request to the RBHA for copies of the checks, either the first paid claim on checks where a single claim was paid or the third paid claim on checks where multiple claims were paid.
- The RBHA will be given 10 business days to submit the requested information to the appropriate RBHA Representative.
- The RBHA Representative will review the submitted information and provide the RBHA with the outcome within 10 business days from the day the second request was received. RBHAs will be sent a preliminary letter summarizing the findings along with a spreadsheet of the claims reviewed.

Check Register Received:

Once the RBHA Representative receives a check register, the review will begin. Within 5 business days of receiving the check register, the RBHA Representative will submit a second request (Attachment 2) and a Check Register Claim Request spreadsheet (attachment 3), via email, to the RBHA for the FFS claims and copies of the checks, either the first paid claim on checks where a single claim was paid or the third paid claim on checks where multiple claims were paid. The RBHA will be given 10 business days to submit the requested information to the

RBHA Representative. Upon receipt of the FFS claims request, the RBHA Representative shall begin the sample selection process.

Sample Selection Process:

The RBHA Representatives have two weeks to research the submitted information by randomly selecting 20% (not to exceed 150) of the encounters to review for correctness, timeliness or omission errors. If the check register contains fewer than 30 check numbers associated with Fee-For-Service paid claims, the entire check register will be reviewed.

How to Determine Encounter Errors:

Correctness: The service dates, procedure code, modifier, units, dollar amounts, and diagnosis codes are compared against a copy of the providers' claim, which is supplied to the RBHA Representative by the RBHA. If what the RBHA adjudicated in their system does not match what the provider billed, a correctness error will result. If both a correctness and timeliness error are found on a single encounter, only the correctness error is calculated into the score. RBHAs must adjust all correctness errors found and resubmit to DBHS within 30 days from the date the preliminary letter was sent to the RBHAs.

Timeliness: An encounter must reach the CIS system at DBHS within 210 calendar days from the end date of service billed, or the encounter is considered untimely, and will result in a timeliness error. Additionally, adjustments of an encounter must be completed and accepted into CIS within 210 calendar days from the end date of service billed to be considered timely.

Omissions: RBHA representatives are to work closely with the RBHAs before omission errors are cited because RBHAs have 210 calendar days from the end date of service to submit a clean claim to DBHS. The following are the steps a RBHA Representative should follow before calling an omission error:

- Contact the RBHA's Claims department and request documentation of claim status.
- Determine the date the claim was adjudicated in the RBHA's system. The RBHA must provide a screen print to document that the claim is in their system.
- If the claim has been cleanly adjudicated in the RBHA's system with a process date prior to the date the check was written, the encounter is not considered an omission. The RBHA will be required to submit a screen print from their claim system demonstrating the above information.
- If a claim is older than 210 calendar days from the end date of service and has not yet been submitted to DBHS, the encounter is an omission.

If any omissions are identified during the course of the review, the score will automatically default to a 0% rating.

Scoring the Check Register Review:

Within two weeks of receiving the FFS claims from the RBHAs, ADHS/DBHS will compute each RBHAs score by dividing the number of correct claims by the total number of claims reviewed. If any omissions are identified during the course of the review, the score will automatically default to a 0% rating. Score and compliance rating are then based on the following table. Corrective action will be requested as applicable.

Score	Rating
90-100%	Full Compliance
75-89%	Substantial Compliance
50-74%	Partial Compliance
0-49%	Non Compliance

Preliminary Findings:

Within 10 business days from receipt of the claims, the RBHA Representative will prepare and issue the preliminary findings (Attachment 4) including a spreadsheet of the claims reviewed (Attachment 5).

Challenges:

The RBHAs have 10 business days to challenge the preliminary findings of a Check Register Review from the date of the preliminary letter

Final Score:

RBHA representatives must take into consideration any challenges before calculating the final score of the quarterly Check Register Review. The final score must be determined within 5 business days from the due date provided in the preliminary letter, and a final letter sent to the RBHA stating the number of errors and the final score (Attachment 6).

Correction of Errors:

It is the expectation of the Office of Program Support that all correctness and omission errors will be corrected and/or submitted within 30 days from the date of the final letter. The RBHA Representative will monitor CIS to ensure corrections are made in a timely manner. If corrections have not occurred the issue will be discussed with the RBHA at the Workgroup meetings.

Admin Review Scoring:

The Check Register Review process is monitored as part of the RBHA's yearly Administrative Review. Complete information regarding the scoring of Administrative Review standards can be found in the Administrative Review section of this manual.

Check Register Request Template Attachment 1

[Date of Request]

In accordance with the following schedule the Office of Program Support is beginning the [1st, 2nd, etc.] Quarter, fiscal year [2007], Check Register Review process. Please submit Fee-For-Service (FFS) check registers for the months of [i.e. October, November, and December] [Year], to the attention of [RBHA Representative] by [10 Business Day's from Date of Request].

Quarterly Review Month	**Check Register Requested**
October 2006	1st quarter, fiscal year 2007
January 2007	2nd quarter, fiscal year 2007
April 2007	3rd quarter, fiscal year 2007
July 2007	4th quarter, fiscal year 2007

If you have any questions please do not hesitate to contact me.

[RHBA Representative]
[Title]
[Phone]
[Fax]
[Email Address]

FFS Claims Request Template

Attachment 2

Subject: [FY07 – 2nd Quarter], FFS Claims Request

Dear [Recipient],

Thank you for your response to the previous check register request. DBHS/OPS has reviewed the check register for the quarter ending [December 2006], and has randomly selected a 20% sample of checks associated with the Fee-For Service paid claims. The next step in the review process will be to examine the paid FFS claims. Please submit the third paid claim from each of the checks listed on the attached spreadsheet. If the identified check contains less than three paid claims, please provide a copy of the first paid claim. This information should be sent to the attention of [RHBA Representative] by [End of Month].

Please feel free to contact me should you have any questions or require any additional information.

Thank you,
[RBHA Representative]
[Title]
[Phone]
[Fax]
[Email Address]

Attachment 3

Check Register Claim Request

RBHA:

Quarter Reviewing: Register Month Requested:

Please provide DBHS with the third paid claim from each of the listed checks. If the identified check contains less then three paid claims, please provide a copy of the first paid claim.

Check Number	Check Date	Vendor	Check Amount	Invoice Number	Invoice Date	Invoice Amount	Payment Amount

Page Of

Attachment 4

Check Register Review Preliminary Letter Template

[Date]

[Recipient]
[RBHA]
[Street Address]
[City, State Zip]

Dear [Dr./Mr./Ms.] [Recipient],

The Division of Behavioral Health Services/Office of Program Support (DBHS/OPS) has concluded its preliminary findings of the [*first, second, etc.*] quarter, fiscal year [2007] Fee-For-Service (FFS) Check Register Review. The claims in the attached Check Register Review Summary have been researched to determine if omission, correctness or timeliness errors exist. If a claim has both a correctness and timeliness error, only the correctness error has been calculated in the findings. If any omissions were identified during the course of the review, the score was automatically defaulted to a 0% rating.

Type of Error	Encounters Reviewed	Number of Errors	Compliance Rate
Correctness			%
Omission			%
Timeliness			%
Total			%

Score Rating	
90-100%	**Full Compliance**
75-89%	**Substantial Compliance**
50-74%	**Partial Compliance**
0-49%	**Non Compliance**

The preliminary score of this review is [ ]%, which represents [*Score Rating*] Compliance. Any challenges must be presented to OPS within 10 business days from the date of this letter. If you have any questions regarding your score or the Check Register Review process, please do not hesitate to contact me at (602) [Phone Number].

Sincerely,

[Name]
Encounters Unit Supervisor

Enclosures

c: [Name], OPS Manager ADHS/DBHS
[Name], Eligibility/Encounter Manager ADHS/DBHS
OPS RBHA Representatives
Contract Compliance File

Check Register Review Encounter Summary Template

Attachment 5

DBHS/OPS Check Register Review Summary

Client ID	Provider ID	Claim					CIS							PMMIS								Error Found						Comments
																								Correctness				
		DOS	Service Code	Units	Billed Amount	Diagnosis code	ICN	DOS	Service Code	Units	Billed Amount	Diagnosis Code	CIS Add Date	CRN	DOS	Service Code	Units	Billed Amount	Diagnosis Code	PMMIS Add Date	Encounters Status	Omission	Timeliness	Service Code	Diagnosis Code	Units	Billed Amount	

Total Clean Claims Divided By the Total Claims = Score
Clean Claims _____ Total Claims ______ Score _____

Page 1 of 1

Check Register Review Final Letter Template Attachment 6

[Date]

[Recipient]
[RBHA]
[Street Address]
[City, State Zip]

Dear [Dr./Mr./Ms.] [Recipient],

The Division of Behavioral Health Services/Office of Program Support (DBHS/OPS) has completed the [*first, second, etc.*] quarter, fiscal year 2007 Fee-For-Service (FFS) Check Register Review. The claims in the Check Register Review Summary were reviewed to determine if omission, correctness or timeliness errors exist. If a claim has both a correctness and timeliness error, only the correctness error has been calculated in the findings. If any omissions are identified during the course of the review, the score will automatically default to a 0% rating.

Type of Error	Encounters Reviewed	Number of Errors	Compliance Rate
Correctness			%
Omission			%
Timeliness			%
Total			%

Score Rating	
90-100%	**Full Compliance**
75-89%	**Substantial Compliance**
50-74%	**Partial Compliance**
0-49%	**Non Compliance**

The final score of this review is [ ]%, which represents [*Score Rating*] Compliance. It is the expectation of OPS that all correctness errors will be corrected and submitted within 30 days from the date of this letter. If you have any questions regarding your score or the Check Register Review process, please do not hesitate to contact me at (602) [phone number].

Sincerely,

[Name]
Encounters Unit Supervisor

Enclosures

c: [Name], OPS Manager ADHS/DBHS
[Name], Eligibility/Encounter Manager ADHS/DBHS
OPS RBHA Representatives
Contract Compliance File

OPS/RBHA Workgroups

Introduction:

In an effort to maintain consistency throughout the Office of Program Support (OPS), the following meeting guidelines should be used for the T/RBHA Eligibility, Enrollment and Encounter Workgroup Meetings.

Workgroup Meeting Scheduling:

RBHA Workgroup meetings are to be held on a monthly basis with each RBHA scheduled during a separate week from the other RBHAs. The schedule has been established as follows:

S*chedule is subject to change.*

GSA 6	1st Wednesday of every month	10:00AM-12:00AM
GSA 2 & 4	2nd Tuesday of every month	9:00AM-11:00AM
GSA 3 & 5	3rd Tuesday of every month	9:30AM-12:00PM
GSA 1	4th Thursday of every month	9:30AM-11:00AM

TRBHA Workgroup meetings are to be held on a quarterly basis, scheduled in the months of January, April, July and October. Although subject to change, the Pascua Yaqui Workgroup should be scheduled in the afternoon following a GSA 3 & 5 Workgroup. The Navajo Nation Workgroup should take place in the afternoon following a GSA 1 Workgroup. The Gila River Workgroup should be scheduled for conference call or on-site at Gila River based on availability.

Agendas:

- The agenda should be completed using the **Meeting Agenda/Minutes Template** (Attachment 1)
- Research any agenda item submitted by the T/RBHA as soon as it is presented. Accepting only a topic from the T/RBHA and adding it to the agenda is insufficient, the RBHA Representative should also document the specific questions the RBHA has regarding the topic.
- When an edit reason is discussed the RBHA Representative **must** include the description of the edit along with the edit number. Additionally, any time a number is used to identify an item the written description must be given.
- One week before the meeting, distribute the *final agenda* to the RBHA.
- Workgroup agendas **must** be completed at least one day prior to the date the agenda is due to a RBHA so that it may be reviewed and approved by a supervisor or manager.

Before the Workgroup Meeting:

Once a final Workgroup agenda has been sent to a RBHA, the RBHA Representative is

responsible for hosting an internal meeting, known as a pre-briefing, to inform all DBHS parties that will be attending the Workgroup of all issues to be discussed. Any clarification of an issue should be made at this time.

Conducting the Workgroup Meeting:

- Before the Workgroup meeting begins, the RBHA Representative shall have the OPS Administrative Assistant prepare enough copies of the following items for hand out to all persons attending the Workgroup:

  - ✓ Agenda
  - ✓ Daily Submission Report
  - ✓ 210 Report
  - ✓ Aged Pends Report
  - ✓ Intakes without Demographics Report
  - ✓ Encounter Withhold Report (if available)

- A sign-in sheet must be completed for <u>every</u> Workgroup meeting. Blank sign-in sheets for each RBHA can be found in the "M:\Program Support Staff\RBHA Meeting Minutes" folder. The following is an example of the sign-in sheet:

Eligibility, Enrollment, and Encounter Workgroup

OPS/Appropriate RBHA

Date

NAME	SIGNATURE	Agency	Phone number

- Workgroup Meetings are to be recorded, but the tapes are only to be reviewed in extreme cases for clarification if a situation necessitates. The RBHA Representatives should rely heavily upon their notes taken during the Workgroup and de-briefing to produce the minutes.

- The Workgroup shall be conducted in the order the agenda (Attachment 1) is written. The order is as follows:

Old Business:

Old Business items should be discussed first. If an old item has not been resolved a detailed explanation of what has been done to correct the situation should be documented and discussed. When addressing an "Old Business" item, refer to the person previously documented as being responsible for follow up, and ask for an update.

Standard Issues:

- ✓ *Daily Submission Report* – Provided to advise the RBHA of their acceptance rate and to make sure the acceptance rate stays at 90% or greater. RBHA Representatives should include any comments sent by the RBHA to explain instances where the acceptance rate was not 90%.

- ✓ *210 Report* – Provided to identify claims submitted by the RBHA past the 210 day filing time requirement.

  - o Print the 210 report for the month prior to the date of the Workgroup meeting.
  - o Enter the report findings on the Workgroup meeting agenda. The agenda should display the findings from the current and previous report.

- ✓ *Aged Pends-Report* – Provided to advise the RBHA of the number of pends they have that exceed or are getting close to the 120-day limit.

- ✓ *Intakes without Demographics Report* – Provided to advise RBHA of the number of intakes currently in the system without a demographic.

- ✓ *Submission Schedule* – Provided by OPS to advise the RBHA if they are adhering to their reported submission schedules for all form types. The RBHAs current submission schedule should be listed in this section.

- ✓ *Override/Delete Log Request* – Advise the RBHA of upcoming due dates for the Override/Delete Log submission.

- ✓ *Check Registers Review Process* – Advise the RBHA when the due dates are for submitting their check registers for the quarterly review process. In addition advise the RBHA of any corrections from previous studies that have not been completed.

- ✓ *Data Validation Update* – Advise the RBHA of any data validation results i.e. ride-alongs and of any upcoming due dates.

- ✓ *Training* – Inquire if any training has taken place since the last meeting. If the RBHA has conducted training, request a summary of the training content and a copy of the sign-in sheet.

New Issues:

New Issues should be logged with the date presented and the person assigned to do the research/follow-up. These issues should be researched immediately after the meeting not just before the next scheduled meeting. If the issue/problem is resolved prior to the next meeting the RBHA Representative should contact the T/RBHA to advise and update the information on the next agenda. The issue can be closed at the next meeting if the T/RBHA agrees.

Closed Issues:

Closed Issues may be removed immediately after both the T/RBHA and OPS agree that the issue is resolved. Closed items should be moved to the Closed Items Log (Attachment 2) for the T/RBHA. RBHA Representatives must remember to bring at least one copy of the Closed Items Log to each Workgroup meeting.

Following the Workgroup:

Following a Workgroup meeting, RBHA Representatives are to immediately begin documenting all discussions from the Workgroup, known as minutes, upon return to ADHS/DBHS.

Minutes:

Minutes shall be completed using the **Agenda/Meeting Minutes Template** (Attachment 1). Meeting minutes must be discussed the day of or the day after the Workgroup at a De-briefing meeting. The De-briefing is the forum that shall be used to clarify any discussions that took place during the Workgroup meeting. The RBHA Representative is responsible for scheduling and hosting this meeting. Minutes should be typed by a RBHA Representative immediately following the De-briefing so the information is still fresh in their mind. Typed minutes are due to the supervisor or manager two (2) business days after the Workgroup. Upon review and approval by a supervisor or manager, the meeting minutes are to be distributed to the attendees no later than three (3) business days from the date of the meeting.

Attachment 1

Appropriate RBHA/Office of Program Support Meeting _____
Enter Agenda or Minutes Above

Created Date:
Final Date:

Current Meeting Date
Place
Time

Attendees:

RBHA: OPS: Absent:

Issue:	*Date reported:*	*Discussion:*	*Action:*	*Assignment:*
Old Business:				
Standard Issues:				
Daily Submission Report				
210 Report				
Aged Pends				
Intakes w/o Demographics Report				
Submission Schedule				
Override/Delete Logs, Due Date				
Check Register, Due Date				
Data Validation Update				
Training				
NPI				
Encounter Withhold				
New Business				
Next Meeting:				

Next Meeting Date
Place
Time

Page 1 of 1

Attachment 2

Appropriate RBHA/Office of Program Support
Closed Items

Issue:	*Date Reported:*	*Date Closed:*	*Discussion:*	*Action:*	*Assignment:*

Edit Alert

Introduction:

An Edit Alert is the method used by the Office of Program Support (OPS) to notify the RBHAs of system changes that may impact the RBHA.

Notifying RBHAs of System Changes:

Whenever possible the OPS will notify the RBHA 90-days prior to the implementation of system modifications. There may be instances when the 90-day notification notice is not possible i.e. legislative requirements or emergency production corrections. If one of these situations occurs, the RBHA will be notified as soon as possible. These notifications will be communicated thru Edit Alerts, and reiterated during RBHA/IT and Encounter Workgroup meetings.

Create and Distribute the Edit Alert:

Once an SSR is written for a system modification, and the originator has obtained all of the required signatures, the original yellow SSR will be delivered to the IT Department and a copy will be delivered to the OPS Encounters Unit Supervisor and the Testing Coordinator.

It is the responsibility of the Encounters Unit Supervisor and/or Testing Coordinator to draft an Edit Alert. The Edit Alert will contain the following:

- The system change
- Scenarios (if applicable)
- The SSR number and description
- The expected implementation date

The completed Edit Alert is emailed to the RBHAs and distributed to OPS and ITS staff. A second Edit Alert will be emailed to advise the RBHA that testing of the change has been completed and the exact date production will be updated.

Edit Alert Database:

To view and/or modify an Edit Alert in the database (Attachment 1), the RBHA Representative will need to take the following steps.

1. Open the “Edit Alert” database by double-clicking on the desktop shortcut. If the shortcut is not available, go to the following target location: M:\Program Support Staff\Edit Alert Database\Edit_Alert_db, then double-click on the Edit_Alert_db.mdb file.

2. Select “New/Changed Edit Alert” from the Main menu.

3. To review an Edit Alert, you can either scroll through the Edit Alerts, which are tracked by number, or do a search with specific wording, creation date, or Edit Alert number.

4. To modify an Edit Alert, locate the Edit Alert that needs modification or revision and populate the Edit Alert with new text. No save option is available because the MS Access database immediately saves each entry.

5. To add an Edit Alert, go to the record beyond the last Edit Alert for a blank form. Populate all Edit Alert database fields, keeping in mind that the Edit Alert will be distributed to all RBHAs and OPS staff. Information entered should be specific and match the SSR.

6. To create a snapshot of any Edit Alert, click on the box with the “camera and document”. A snapshot of the Edit Alert will be created in the RBHA Representatives F:\ drive.

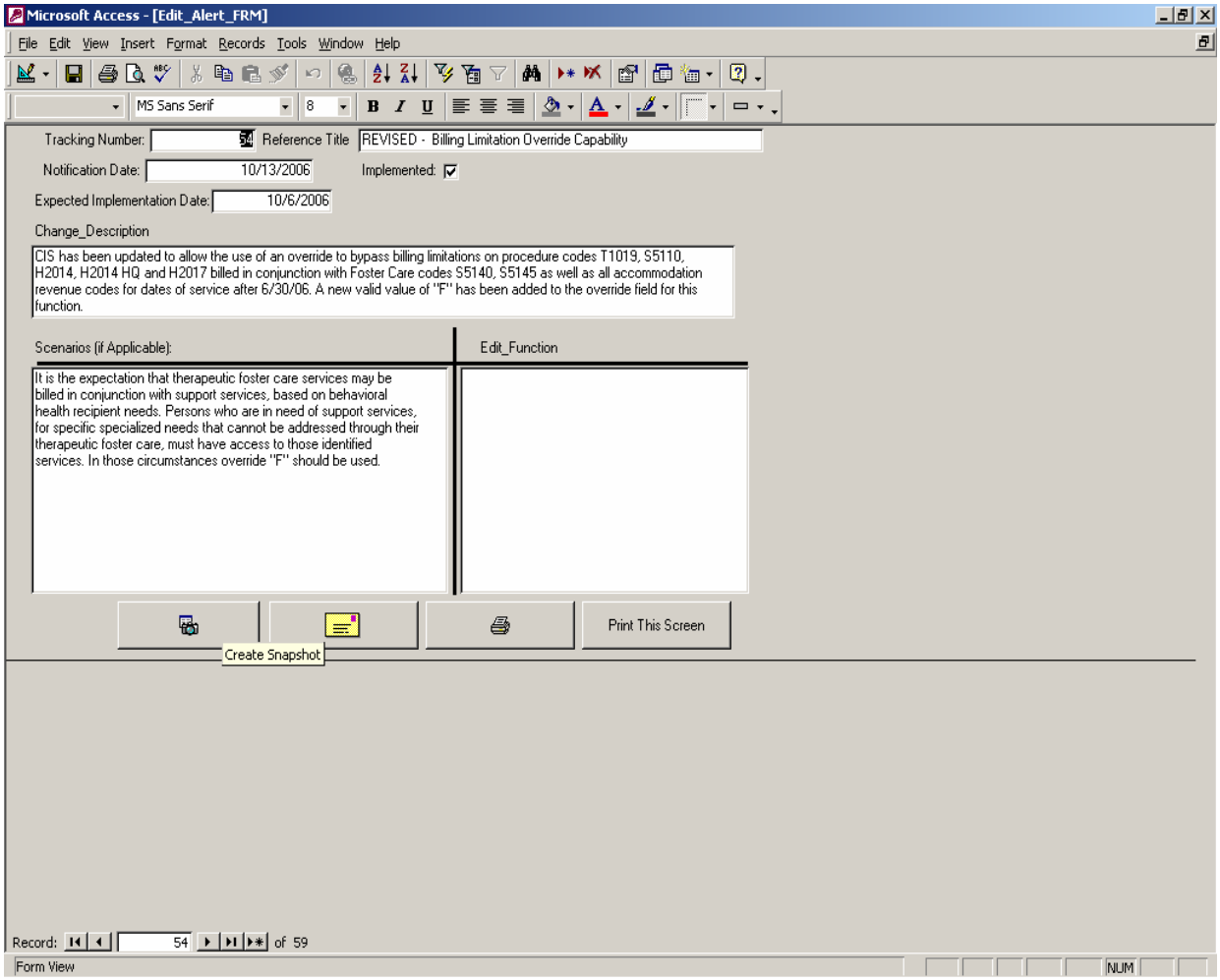
7. Anytime an Edit Alert is sent, whether internally for OPS/IT staff or out to the RBHAs, it must be in the form of a snapshot.

Implementation

Once implementation takes place, an Edit Alert will be emailed to advise the RBHA of the exact date production will be updated.

Attachment 1

Edit Alerts Database



Attachment 2

Sample Edit Alert

New/Changed Edit Alert

Tracking_Number: 69 **Implemented:** ☐

Reference Title Demographic - AXISIII Field Change

Notification Date: May 25, 2007

Expected Implementation Date: July 1, 2007
ADHS will provide the RBHA's with 90 days notice when possible

Change Description: Establish a field that stores behavioral health recipient's current medical diagnoses. (SSR 2178)

The current data set submitted by the T/RBHA to BHS utilizes five 2-byte fields, which indicate a generic category of the recipient's current medical condition(s). ADHS must identify whether the behavioral health recipient reports as having any of 36 AHCCCS-specified diagnoses.

The new field will identify specified conditions of behavioral health recipients for which coordination of care should be provided. The Coordination of Care performance measure and other potential analysis will be extrapolated through examination of this data.

The existing AXISIII field(s) will remain in the data set, but field-specific edits for records with an intake date of MM/DD/YYYY (system change date) or later will be ignored/modified. Data submissions with an intake date of MM/DD/YYYY (system change date) or later will not require completion of the existing AXISIII field(s).

The new field will store up to three 2-byte codes. A maximum of three unique codes may be stored per individual record. Either Not Applicable (N/A) or a valid code must be entered. If N/A is entered as the first of the 3 possible entries, then N/A must also be entered for subsequent entries. Exact codes, other than N/A, cannot be repeated in an individual record. If more than one field is completed with any valid value other than N/A the codes must be unique.

This change will enable ADHS/DBHS to be more in sync with AHCCCS' system and will decrease the number of encounters pending at AHCCCS.

Special Day Runs

Introduction:

The Office of Program Support recognizes that there may be occasions when a RBHA will need to submit encounters or demographics separate from the normal nightly submission. These type of submissions are considered special day runs and can be utilized to test changes made to the RBHA's system or to isolate a specific group of encounters. In addition, encounter form type(s) that have been restricted to the test environment, special day runs will be the only form of submission until the test criteria has been satisfactorily met.

Request Process:

Special day runs will only be performed by ADHS on Wednesdays. The RBHA must coordinate with their RBHA Representative to schedule a special day run. The following are the procedures that must be performed:

- The RBHA must submit an electronic request, by Noon on Tuesday, including encounter volumes and specific details of what is being submitted and why.
- The RBHA Representative will review the request with the appropriate OPS management.
- The RBHA Representative will notify the RBHA electronically of the request approval or denial by COB Tuesday.
- If the request is approved the RBHA Representative will copy the IT department to alert them that a special day run will be submitted the next day.

Processing the Special Run Day:

To successfully complete the special day run request the RBHA must:

- Ensure files are not placed on the FTP server prior to Wednesday morning (files placed on the server prior to Wednesday morning risk being picked up by the nightly processing)
- Ensure the files are submitted to the FTP server by 10:00 a.m. on Wednesday

Correct Reporting of Ancillary Charges

Incorrect Billing

UBs submitted in this manner will fail CIS pre-processor edit, N228 UB ancillary line with zero/blank units or dollars.

Line	Rev Cd	Units	Billed	NonCovChg	Paid	Description
01	134	5	2960.00	000.00		Psych/3&4 Bed
02	251	1	0.00	000.00		Drugs/Generic
03	301	32	0.00	000.00		Lab/Chemistry
04	302	1	0.00	000.00		Lab/Immunology
05	305	1	0.00	000.00		Lab/Hematology
		Total	**2960.00**		**2960.00**	

Line	Rev Cd	Units	Billed	NonCov Chg	Paid	Description
01	134	5	3650.00			Psych/3&4 Bed
02	251	1	450.00			Drugs/Generic
03	301	32	400.00			Lab/Chemistry
04	302	1	150.00			Lab/Immunology
05	305	1	150.00			Lab/Hematology
		Total	**4800.00**		**2960.00**	**Total paid for entire claim**

Correct Billing

The providers should bill UBs to the RBHAs exactly as they would bill any private insurance carrier. Ancillary revenue codes, units, and amounts must be reported on all inpatient UBs The rates reported should not be the contracted amount or the amount the RBHA is expected to pay but the actual amount of the service. The RBHAs will report their contracted amount for the service in the paid field.

Line	Rev Cd	Units	Billed	NonCov Chg	Paid	Description
01	134	5	3650.00	690.00		Psych/3&4 Bed
02	251	1	450.00	450.00		Drugs/Generic
03	301	32	400.00	400.00		Lab/Chemistry
04	302	1	150.00	150.00		Lab/Immunology
05	305	1	150.00	150.00		Lab/Hematology
		Total	**4800.00**		**2960.00**	**Total paid for entire claim**

Correct Reporting of Same Day Admit/Discharge Encounters

Inpatient encounters for clients who are admitted and discharged on the same date will be allowed for ancillary services only. These UB92/UB04 inpatient encounters with the same start and end date must be submitted as follows:

Line	Rev CD	Units	Billed	NonCov Chg	Paid	Description
01	134	1	1200.00	1200.00	0.00	Psych/3&r Bed
02	251	1	450.00	0.00	450.00	Drugs/Generic
03	301	32	400.00	0.00	400.00	Lab/Chemistry
04	302	1	150.00	0.00	150.00	Lab/Immunology
05	305	1	150.00	0.00	150.00	Lab/Hematology
		Total	2350.00		1150.00	Total paid for claim

Duplicate Encounter Logic

Introduction:

ADHS/DBHS/OPS has system edits in place to prevent exact duplicate encounters from being accepted into CIS. In addition ADHS/DBHS/OPS has potential duplicate edits that require review and intervention on the part of the RBHA. Duplicate logic is applied to an encounter when another encounter exists in the database or on the file being submitted by the RBHA. The following are the logic used in these edits for each form type

Exact Duplicate Logic:

UB92/UB04 will reject when the fields listed below are the same
- Client ID
- Provider ID
- Dates of service
- First 2 digits of bill type

1500 will reject when the fields listed below are the same
- Client ID
- Provider ID
- Service/Procedure Code
- Date of service
- Modifier
- Place of service

Pharmacy/NCPDP will reject when the fields listed below are the same
- Client ID
- Provider ID
- NDC
- Dispense date

Potential Duplicate Logic:

Two additional edits exist that use similar logic to the duplicate logic and when failed will require review and intervention by the RBHA. There are no override capabilities available for these edits.

1500 will reject when the fields listed below are the same
- Client ID
- Provider ID
- Service/Procedure Code
- Modifier
- Place of service

However, dates of service are overlapping

- Fail N254-overlapping dupe in file
- Fail N255-overlapping dupe in database

Pharmacy/NCPDP will reject when the fields listed below are the same

- Client ID
- NDC
- Dispense date

However, provider is different

- Fail N256-NDC/different provider in file for date of service
- Fail N257-NDC/different provider in database for date of service

RBHA Resync Requests

Introduction:

The Office of Program Support recognizes that there may be occasions when a RBHA will need to have a file of all data as reflected in the DBHS computer system. This type of request is called a "resync" and may be utilized by the RBHA for the purpose of performing a reconciliation or due to processing problems.

Request Process:

The RBHA must coordinate with their RBHA Representative to schedule a "resync". The RBHA will send an e-mail to their RBHA Representative and will copy the Encounter Manager with a request for a "resync". The Request must contain the following information:

- RBHA name and GSA

- Type of resync(s) requested:
  - ✓ AHCCCS Eligibility
  - ✓ Closure
  - ✓ Demographic
  - ✓ Encounter
  - ✓ Intake

- Date range:
  - ✓ Fiscal year (July 1 – June 30)
  - ✓ Calendar year (January 1 – December 31)
  - ✓ Any other time increment (quarter, month, etc.)

The T/RBHA Representative will forward the e-mail notification to the identified IT contact and will copy BHS/ITS Management.

Request received prior to 2:00 p.m. should be completed in approximately 2 – 4 hours. Requests received after 2:00 p.m., files will not be made available until the next day.

The T/RBHA Representative will be notified by BHS/ITS when the files are available on the FTP Server. The T/RBHA Representative will then notify the RBHA via e-mail with the file names.

OPS/RBHA Ride-Along

Introduction:

The purpose of the data validation ride-along is to evaluate the process of the RBHA to ensure they are accurately and thoroughly performing their data validation studies. Additionally, it is an opportunity for DBHS/OPS to perform a quarterly provider data validation study with the RBHAs similar to the yearly AHCCCS study.

A Data Validation Representative will accompany each RBHA on a minimum of two provider data validation studies and at least one follow-up review per GSA per quarter. For the purposes of the DBHS/OPS ride-along, a minimum of 25% of the medical records pulled for the data validation study will be reviewed by the DBHS/OPS Data Validation Representative. It is the Data Validation Representative's responsibility to schedule the quarterly ride-along with the RBHA and will ensure that each GSA is reviewed.

Sample Selection Process:

The RBHA is required to perform a data validation review in accordance with the *Data validation Procedure Code Review Schedule (attachment 1)* on a minimum of 10% of their providers per GSA each quarter. Provider refers to all behavioral health providers under contract with a RBHA or a RBHA network that deliver services to behavioral health clients (any provider that the RBHA will receive a claim/encounter from). The RBHA is responsible for establishing the sample size, randomly selecting the medical records to be reviewed and notifying the provider of the upcoming data validation study. Sample size should be reflective of the number of encounters submitted by the provider during the review quarter. For example, if a provider only submitted 10 encounters during the quarter all 10 should be reviewed. However, if the provider submitted 1,000 encounters the RBHA should review a percentage that would reflect a reasonable sample. The Data Validation Representative will review all services in the medical record for the review quarter not just the services identified on the *Data validation Procedure Code Review Schedule (attachment 1).*

The RBHA is required to provide OPS a complete schedule of their on-site reviews for each GSA at least **30** business days prior to the beginning of the review quarter. At a minimum the RBHA must include the GSA, the date of the review, the name of the provider/agency to be reviewed, the provider's AHCCCS ID number including the provider type and the address where the review will be performed.

Quarterly Data Validation Review Schedule

Review Quarter	Dates of Service Reviewed
Ending March 31	July, August & September of previous year
Ending June 30	October, November & December of previous year
Ending September 30	January, February & March of current year
Ending December 31	April, May & June of current year

Example: In June 2006 the quarterly review will be for services provided in October, November and December of 2005.

Ride-along:

At or prior to the on-site visit, the RBHA is responsible for providing OPS staff with a file containing the download from their claims system and a copy of the RBHA's contract with the provider. This file should contain all claims processed in the RBHA's system for the clients and the dates of service to be reviewed.

OPS will select a sample of the charts pulled by the RBHA, each medical record will be reviewed and independently coded by the RBHA and OPS. The service code, place of service, modifier, number of units, and diagnosis code will be documented on the *DBHS/OPS Data Validation Ride-Along Summary* spreadsheet (Attachment 2) as the appropriate code for the services documented by the provider. In addition, the date of the last assessment should be indicated on the *DBHS/OPS Data Validation Ride-Along Summary* spreadsheet. In an effort to assist the QM department other key fields of the assessment may be reviewed. OPS will review medical record findings with the RBHA prior to completing the ride-along.

After the on-site visit, the Data Validation Unit will review the encounters on file in CIS to determine if the claims have been submitted and verify that there are no discrepancies between the service codes, place of service, modifier, number of units, and diagnosis codes documented in the medical record and the encounter data.

DBHS/OPS Data Validation Ride-Along Summary

Provider: Date: RBHA:

Client Name/ Client ID	DOB	Provider ID	Per Audit							RBHAs System						Per CIS							Contract Review		Error Found							Comments
			Assessment Dt	DOS	Service Code	Modifier	Place of Service	Units	Diagnosis Code	DOS	Service Code	Modifier	Place of Service	Units	Diagnosis Code	ICN	DOS	Service Code	Modifier	Place of service	Units	Diagnosis Code	Rec'd Date	Rate identified in Contract	Rate on Encounter	Omission	Timeliness	Correctness					
																												Service Code	Modifier	Place of Service	Units	Diagnosis Code	

Completion of Spreadsheet:

There are five sections of the Data Validation Ride-Along spreadsheet that will be completed by the Data Validation Representative. The sections are Per Audit, RBHA's System, Per CIS, Contract Review and Errors Found.

Per Audit- to be completed on site during the ride-along:

- Client name and ID, enter from the medical records or from the RBHA's printout of services found in the RBHA's system.
- Date of Birth (DOB), enter from the medical records or from the RBHA's printout of services found in the RBHA's system.
- Provider ID, enter from the medical records or from the RBHA's printout of services found in the RBHA's system.
- Assessment Date, review medical records and indicate the date of the most recent assessment.

- Date of Service (DOS), review medical records and indicate the dates of the services within the review period.
- Service Code, review medical records and list the appropriate service code for the description provided.
- Modifier, review medical records and list the appropriate modifier for the description provided.
- Place of Service, review medical records and list the appropriate place of service code for the description provided.
- Units, review medical records and list the appropriate units for the service description provided.
- Diagnosis Code, review medical records and list the appropriate diagnosis code for the description provided.

RBHA's System-can be completed on site or when you return to BHS. This information will be used to determine if the RBHA has the encounter correctly and it was not sent to CIS correctly or if the provider submitted the information incorrectly to the RBHA.

- Date of Service (DOS), review RBHA's system file and indicate the dates of the services within the review period.
- Service Code, review RBHA's system file and list the service code billed to the RBHA.
- Modifier, review RBHA's system file and list the modifier billed to the RBHA.
- Place of Service, review RBHA's system file and list the place of service code billed to the RBHA.
- Units, review RBHA's system file and list the units billed to the RBHA
- Diagnosis Code, review RBHA's system file and list the diagnosis code billed to the RBHA

Per CIS- using the Client Information System the Data Validation Representative will complete after returning to BHS. Entering the client, provider and date of service information the Representative will see a list of all the services received as encounters.

- ICN, list the internal control number assigned to the located encounter
- DOS, list the date of service as it was submitted to CIS on the encounter.
- Service Code, list the service code as it was submitted to CIS on the encounter.
- Modifier, list the modifier as it was submitted to CIS on the encounter.
- Place of Service, list the place of service as it was submitted to CIS on the encounter.
- Units, list the units of service as it was submitted to CIS on the encounter.
- Diagnosis Code, list the diagnosis code as it was submitted to CIS on the encounter.
- Rec'd Date, list the received date of the appropriate encounter as it was submitted to CIS.

Contract Review- using the a copy of the providers contract and the Client Information system the Data Validation Representative will complete after returning to BHS. Entering the contracted amount for the services provided and the amount billed on the encounter.

- Rate identified in contract, list the contracted amount per service provided
- Rate on encounter, list the billed amount on each encounter found

Error Found-this section will be used to indicate any error found when the Per Audit section is compared to the Per CIS section.

- Omission, an omission error will be called when a service is identified in the medical record but is not found in CIS.
- Timeliness, a timeliness error will be called when the received date in CIS is greater than 210 days from the last day of the month in which the service was rendered.
- Correctness/Service Code, a service code correctness error will be called when the service code from the medical record does not match the service code in CIS. A correctness error on the service code includes the modifier and place of service.
- Correctness/Diagnosis, a diagnosis code correctness error will be called when the diagnosis code does not match the diagnosis code in CIS.
- Correctness/Units, a units error will be called when the do not match the units in CIS.
- Non-billable, a non-billable error will be called when documentation is found in the chart that does not substantiate a billable service or when an encounter is found in CIS but documentation was not found in the chart.
- Comments, the comments section will be used to further explain any errors or additional findings from the review. The comments will also indicate if the error is also in the RBHA's system.

Exit Interview:

The RBHAs are required to perform an exit interview with each provider at the time of the review. The Data Validation representative(s) at the ride-along will attend the exit interview and will be available to assist with provider questions.

After the Ride-Along:

Within five business days after the ride-along, the Data Validation Unit will prepare and issue a summary of the ride-along, which will include the number of records reviewed, the number of errors found, the review score, any training issues identified, and if required, requests for corrective action. DBHS will give the RBHA a date by which the omission errors must be submitted. The RBHA will also be required to correct and resubmit the correctness errors by that same date. The Data Validation Representative will copy the RBHA Representatives on all correspondence.

Type of Error	Number Reviewed	Number of Errors	Error Rate
Correctness: Service Code			
Correctness: Modifier			
Correctness: Place of Service			
Correctness: Units			
Correctness: Diagnosis Code			
A single encounter may have more than one correctness error, however the encounter will only be counted once in the total calculation			
Timeliness			
Omission			
	Encounter Total	**Encounters w/Errors**	**Error Rate**
Total			

The RBHA has two weeks to review the response and either challenge the findings or provide information on when DBHS can expect all corrections to be completed. The Data Validation unit will review the response submitted by the RBHA who will then be notified, within 2 business days, if the plan is accepted. If the response is a challenge, the Data Validation Representative reviewing the challenge must provide a response to the RBHA within 5 business days.

The RBHA will be responsible for including the ADHS/DBHS site-visit in their final reports for the quarterly data validation studies.

In the event any one provider has an error rate greater than 10%, the RBHA is required to submit an implementation plan for that provider and perform a second data validation study for that provider within six months. The RBHA will include the date of the follow-up review in the corrective action plan. After completion of the follow-up study, the RBHA will provide DBHS with documentation of the findings.

Providing Information:

Monthly, the Data Validation Representative will provide the RBHA Representative with an update. It will be the responsibility of the RBHA Representative to copy the Data Validation Representative on the "call for agenda items" that is sent to the RBHA prior to the monthly meeting. At that time it will be the Data Validation Representatives responsibility to provide the update, which will include any outstanding responses due from the RBHAs as well as a status on any DBHS deliverables. In addition, the Data Validation Representative will advise the RBHA of any AHCCCS activity.

If fraud is suspected at any time during the DBHS/OPS ride-along, the suspected fraud will be reported to the Corporate Compliance Officer at DBHS.

Data Validation Procedure Code Review Schedule

Attachment 1

Code	Description	Mod.	Place of Service
Codes to be Reviewed for July, August & September Dates of Service			
Inpatient Services			
114	Psychiatric room and board, private		
116	Detox, private		
124	Psychiatric room and board, semi private two beds		
126	Detox, semi private		
134	Psychiatric room and board, semi private three bed and four beds		
136	Detox, 3&4 bed		
154	Room/board Ward Psychiatric		
156	Detox, ward		
183	Home pass		
189	Bed hold		
Residential Services			
S5140	Foster care adult, per diem		12, 99
S5145	Foster care child, per diem		12, 99
H0018	Behavioral health short-term residential, without room and board		99
H0019	Behavioral health long-term residential (non-medical, Non-acute), without room and board		99
Day Programs			
H2012	Supervised behavioral health day treatment, per hour up to 5 hours		53, 71, 72, 99
H2015	Comprehensive community support services, supervised day program per 15 minutes, 6-10 hours		53, 71, 72, 99
H2019	Therapeutic behavioral services day program, per 15 minutes up to 5 3/4 hours		53, 71, 72, 99
H2019	Therapeutic behavioral services day program, per 15 minutes up to 5 3/4 hours	TF	53, 71, 72, 99
H2019	Home therapeutic behavioral services day program, per 15 minutes up to 5 3/4 hours	TF	12
H2020	Therapeutic behavioral services, per diem		53, 71, 72, 99
H2020	Home therapeutic behavioral health day services, per diem		12
H0036	Community psychiatric supportive treatment day program, face-to-face, per 15 minutes		53, 72, 99

Code	Description	Mod.	Place of Service
Codes to be Reviewed for January, February & March Dates of Service			
Rehabilitation Services			
H0020	Alcohol and/or drug services; methadone administration and/or service	HG	11, 22, 50, 53, 71, 72, 99
H0025	Behavioral health prevention/promotion education service (services to target population to affect knowledge, attitude and/or behavior)		11, 12, 50, 53, 71, 72, 99
H0034	(Health promotion) medication training and support, per 15 minutes		11, 12, 50, 53, 71, 72, 99
H2010	Comprehensive medication services, per 15 minutes	HG	04, 11, 20, 50, 53, 72, 99
H2014	Skills training and development, per 15 minutes		11, 12, 50, 53, 71, 72, 99
H2014	Group skills training and development, per 15 minutes per person	HQ	11, 12, 50, 53, 71, 72, 99
H2017	Psychosocial rehabilitation living skills training services, per 15 minutes		11, 12, 50, 53, 71, 72, 99
H2025	Ongoing support to maintain employment, per 15 minutes		11, 12, 50, 53, 71, 72, 99
H2026	Ongoing support to maintain employment, per diem		11, 12, 50, 53, 71, 72, 99
H2027	Psychoeducational service (pre-job training and development), per 15 minutes		11, 12, 50, 53, 71, 72, 99
T1002	RN services, up to 15 minutes		04, 11, 12, 20, 99, 99
T1003	LPN Services, up to 15 minutes		04, 11, 12, 20, 99, 99
Codes to be Reviewed for April, May & June Dates of Service			
Support Services			
H0038	Self-help/peer services (peer support), per 15 minutes		11, 12, 50, 53, 71, 72, 99
H0038	Self-help/peer services group, per 15 minutes	HQ	11, 12, 50, 53, 71, 72, 99
H2016	Comprehensive community support services (peer support), per diem		11, 12, 50, 53, 71, 72, 99
S5110	Home care training, family (family support), per 15 minutes		11, 12, 50, 53, 71, 72, 99
S5150	Unskilled respite care, not hospice, per 15 minutes		12, 99
S5151	Unskilled respite care, not hospice, per diem		12, 99
T1016	Office case management by behavioral health professional, each 15 minutes	HO	11, 50, 53, 71, 72
T1016	Out of office case management by behavioral health professional, each 15 minutes	HO	12, 22, 99
T1016	Office case management, each 15 minutes	HN	11, 50, 53, 71, 72
T1016	Out of office case management by BHT, each 15 minutes	HN	12, 22, 99

Data Validation Procedure Code Review Schedule

Attachment 1

Code	Description	Mod.	Place of Service
Codes to be Reviewed for July, August & September Dates of Service			
Day Programs (continued)			
H0036	Community psychiatric supportive treatment medical day program, face-to-face, per 15 minutes	TF	53, 72, 99
H0036	Home community psychiatric supportive medical treatment face-to-face, per 15 minutes		12
H0036	Home community psychiatric supportive medical treatment face-to-face, per 15 minutes	TF	12
H0037	Community psychiatric supportive treatment medical day program, per diem		53, 72, 99
H0037	Home community psychiatric supportive medical treatment program, per diem		12
Codes to be Reviewed for October,November & December Dates of Service			
Treatment Services			
H0001	Alcohol and/or drug assessment		99
H0031	Mental health assessment, by non-physician 30 minute increments		04, 11, 12, 20, 22, 23, 50, 53, 71, 72, 99
H0002	Behavioral health screening to determine eligibility for admission		11, 12, 22, 50, 53, 71, 72, 99
H0004	Home, individual behavioral health counseling and therapy, per 15 minutes		12, 31, 32, 33, 99
H0004	Out of office, family behavioral health counseling and therapy with client present, per 15 minutes	HR	12, 99
H0004	Out of office, family behavioral health counseling and therapy without client present, per 15 minutes	HS	12, 99
H0004	Office, individual behavioral health counseling and therapy, per 15 minutes		11, 22, 50, 53, 72
H0004	Office, family behavioral health counseling and therapy with client present, per 15 minutes	HR	11, 22, 50, 53, 72
H0004	Office, family behavioral health counseling and therapy without client present, per 15 minutes	HS	11, 22, 50, 53, 72
H0004	Office, group behavioral health counseling and therapy, per 15 minutes	HQ	11, 22, 31, 32, 33, 50, 53, 72, 99

Code	Description	Mod.	Place of Service
Codes to be Reviewed for April, May & June Dates of Service			
Support Services (continued)			
T1019	Personal care services, per 15 minutes (not for inpatient or residential care facilities		04, 11, 12, 20, 50, 53, 71, 72, 99
T1020	Personal care services, per diem (not for inpatient or residential care)		11, 12, 50, 53, 71, 72, 99
Crisis			
S9484	Crisis intervention mental health service, per hour		21, 51, 99
S9485	Crisis intervention mental health services, per diem		21, 51, 99
H2011	Crisis intervention service, per 15 minutes		04, 11, 12, 20, 23, 50, 53, 71, 72, 99
H2011	Crisis intervention service ula 2 person team, per 15 minutes	HT	04, 11, 12, 20, 23, 50, 53, 71, 72, 99

DV Ride-Along Attachment 2

DBHS/OPS Data Validation Ride-Along Summary

Provider: Date: RBHA:

Client Name/ Client ID	DOB	Provider ID	Per Audit							RBHAs System						Per CIS								Contract Review		Error Found							Comments
			Assessment Date	DOS	Service Code	Modifier	Place of Service	Units	Diagnosis Code	DOS	Service Code	Modifier	Place of Service	Units	Diagnosis Code	ICN	DOS	Service Code	Modifier	Place of service	Units	Diagnosis Code	Rec'd Date	Rate identified in Contract	Rate on Encounter	Omission	Timeliness	Correctness						
																												Service Code	Modifier	Place of Service	Units	Diagnosis Code	

Quarterly Report

Introduction:

The RBHAs are required to perform data validation studies quarterly on their providers in accordance with the *Data validation Procedure Code Review Schedule (attachment 1)*. Each record must be reviewed for omission, correctness and timeliness errors. In addition the Quarterly Data Validation reports will be scored as part of the RBHA's yearly Administrative Review.

Reporting Findings:

The RBHA is required to report the findings of the data validation studies to the Office of Program Support no later than the 15th of the month following the end of the quarter. For example, for quarter ending September 30, 2007, the reports are due by October 15, 2007. If the reports aren't received by the 15th the Data Validation Representative will contact each RBHA for a status. Findings should be reported using the *RBHA Data Validation Study Results* form (Attachment 2). A separate form should be completed for each provider reviewed. Action to be taken by the RBHA needs to be specific; the following are examples of acceptable and unacceptable entries.

Example:

RBHA Quarterly Data Validation Study Results

Review Period: _____

RBHA: _____ GSA: _____ Date of Review: _____

Provider Name & ID: _____ Date of Exit Interview: _____

Provider's Score: _____ Date Final Report Sent: _____

	Client Name & ID	# of Services Reviewed	Number of Errors by Type			Action taken by RBHA	Provider Follow-up	Did DBHS Attend
			Omission	Correctness	Timeliness			Y/N
Unacceptable	M. Mouse	20	3	14	not reviewed	will provide training. Provider to correct claims		blank
Acceptable	Minnie Mounse A123456789	20	3	14	5	Provider to be trainied 9/13/07 on proper use of diagnosis codes. Provider advised that omissions and errors must be corrected by 9/30/07	Training provided 9/13/07, sign-in sheets and a brief summary otraining conted attached. 10/1/07 verified that all omissions and errors have been corrected.	Y or N

Definitions of required fields:

- RBHA-Name and GSA
- Provider Name and ID (list one provider per sheet)

- Provider's Score-This is the number of errors identified divided by the number of services reviewed.
- Review Period-This is the quarter reviewed for example quarter ending March 31.
- Date of Exit Interview-the exit interview must be performed at the close of the review
- Date of Final Report-must be within 10 business days from the date of the review
- Client Name-List all clients reviewed for the provider
- # Of Services-Total number of services reviewed per client
- Number of Errors by Type
    1. Omission-The service was documented in the provider's medical record but was not in the RBHAs system.
    2. Correctness-The service documented in the medical record does not match the service in the RBHA's system.
    3. Timeliness-The RBHA must review the submission of the claim in accordance with their established submission time frames.
- Action Taken by RBHA-This information need to be specific and should include the date training will be provided, date omissions will be submitted, date errors will be corrected and any other corrective action required of the provider.

- Provider Follow-up
    1. Training-RBHA will provide the date of training and will attach a copy of the sign-in sheet and brief summary of the training content.
    2. Omission/Correctness Error-RBHA will provide the date of error(s) correction and will provide the ICN of the corrected encounter.

The RBHA will be responsible for including the ADHS/DBHS site-visit in their final reports for the quarterly data validation studies.

Report Received:

After the report is received from the RBHAs the Data Validation Representative will validate that the information provided is complete and will notify the RBHA via e-mail of acceptance or rejection within 2 business days of receipt. The RBHA will have 2 business days to complete and resubmit the report. The Data Validation Representative will then review each report and will provide feedback to the RBHA within in 10 business days after the acceptance of the report. The Data Validation Representative will review each report for the following:

- Did the RBHA submit the report by the 15th?
- Was the report submitted in the proper format with all required fields?
- Did the RBHA review 10% of their provider network per GSA?
- Did the RBHA review each record for omission, correctness and timeliness?
- Are the RBHA's actions to be taken specific?
- Was the exit interview performed at the end of the review?
- Was the final report sent to the provider within 10 business days?
- Did the RBHA correctly identify reviews with DBHS participation?

- How does the score from the RBHA compare to the score from DBHS?
- Were the encounters in error submitted/corrected?

The feedback provided to the RBHA will include the findings of each of the above monitored items and may require the RBHA to make corrections to their process if issues are discovered. Additionally, the Data Validation Representative may perform a follow-up study on passing as well as failing providers reported by the RBHA.

Administrative Review Scoring:

The Quarterly report is monitored as part of the RBHA's yearly Administrative Review. Complete information regarding the scoring of Administrative Review standards can be found in the Administrative Review Section of this manual.

Data Validation Procedure Code Review Schedule

Attachment 1

Code	Description	Mod.	Place of Service
Codes to be Reviewed for July, August & September Dates of Service			
Inpatient Services			
114	Psychiatric room and board, private		
116	Detox, private		
124	Psychiatric room and board, semi private two beds		
126	Detox, semi private		
134	Psychiatric room and board, semi private three bed and four beds		
136	Detox, 3&4 bed		
154	Room/board Ward Psychiatric		
156	Detox, ward		
183	Home pass		
189	Bed hold		
Residential Services			
S5140	Foster care adult, per diem		12, 99
S5145	Foster care child, per diem		12, 99
H0018	Behavioral health short-term residential, without room and board		99
H0019	Behavioral health long-term residential (non-medical, Non-acute), without room and board		99
Day Programs			
H2012	Supervised behavioral health day treatment, per hour up to 5 hours		53, 71, 72, 99
H2015	Comprehensive community support services, supervised day program per 15 minutes, 6-10 hours		53, 71, 72, 99
H2019	Therapeutic behavioral services day program, per 15 minutes up to 5 3/4 hours		53, 71, 72, 99
H2019	Therapeutic behavioral services day program, per 15 minutes up to 5 3/4 hours	TF	53, 71, 72, 99
H2019	Home therapeutic behavioral services day program, per 15 minutes up to 5 3/4 hours	TF	12
H2020	Therapeutic behavioral services, per diem		53, 71, 72, 99
H2020	Home therapeutic behavioral health day services, per diem		12

Code	Description	Mod.	Place of Service
Codes to be Reviewed for January, February & March Dates of Service			
Rehabilitation Services			
H0020	Alcohol and/or drug services; methadone administration and/or service	HG	11, 22, 50, 53, 71, 72, 99
H0025	Behavioral health prevention/promotion education service (services to target population to affect knowledge, attitude and/or behavior)		11, 12, 50, 53, 71, 72, 99
H0034	(Health promotion) medication training and support, per 15 minutes		11, 12, 50, 53, 71, 72, 99
H2010	Comprehensive medication services, per 15 minutes	HG	04, 11, 20, 50, 53, 72, 99
H2014	Skills training and development, per 15 minutes		11, 12, 50, 53, 71, 72, 99
H2014	Group skills training and development, per 15 minutes per person	HQ	11, 12, 50, 53, 71, 72, 99
H2017	Psychosocial rehabilitation living skills training services, per 15 minutes		11, 12, 50, 53. 71, 72, 99
H2025	Ongoing support to maintain employment, per 15 minutes		11, 12, 50, 53, 71, 72, 99
H2026	Ongoing support to maintain employment, per diem		11, 12, 50, 53, 71, 72, 99
H2027	Psychoeducational service (pre-job training and development), per 15 minutes		11, 12, 50, 53, 71, 72, 99
T1002	RN services, up to 15 minutes		04, 11, 12, 20, 33, 99
T1003	LPN Services, up to 15 minutes		04, 11, 12, 20, 33, 99
Codes to be Reviewed for April, May & June Dates of Service			
Support Services			
H0038	Self-help/peer services (peer support), per 15 minutes		11, 12, 50, 53, 71, 72, 99
H0038	Self-help/peer services group, per 15 minutes	HQ	11, 12, 50, 53, 71, 72, 99
H2016	Comprehensive community support services(peer support), per diem		11, 12, 50, 53, 71, 72, 99
S5110	Home care training, family (family support), per 15 minutes		11, 12, 50, 53, 71, 72, 99
S5150	Unskilled respite care, not hospice, per 15 minutes		12, 99
S5151	Unskilled respite care, not hospice, per diem		12, 99
T1016	Office case management by behavioral health professional, each 15 minutes	HO	11, 50, 53, 71, 72
T1016	Out of office case management by behavioral health professional, each 15 minutes	HO	12, 22, 99
T1016	Office case management, each 15 minutes	HN	11, 50, 53, 71, 72

Data Validation Procedure Code Review Schedule

Attachment 1

Code	Description	Mod.	Place of Service
Codes to be Reviewed for July, August & September Dates of Service			
Day Programs (continued)			
H0036	Community psychiatric supportive treatment medical day program, face-to-face, per 15 minutes	TF	53, 72, 99
H0036	Home community psychiatric supportive medical treatment face-to-face, per 15 minutes		12
H0036	Home community psychiatric supportive medical treatment face-to-face, per 15 minutes	TF	12
H0037	Community psychiatric supportive treatment medical day program, per diem		53, 72, 99
H0037	Home community psychiatric supportive medical treatment program, per diem		12
Codes to be Reviewed for October,November & December Dates of Service			
Treatment Services			
H0001	Alcohol and/or drug assessment		99
H0031	Mental health assessment, by non-physician 30 minute increments		04, 11, 12, 20, 22, 23, 50, 53, 71, 72, 99
H0002	Behavioral health screening to determine eligibility for admission		11, 12, 22, 50, 53, 71, 72, 99
H0004	Home, individual behavioral health counseling and therapy, per 15 minutes		12, 31, 32, 33, 99
H0004	Out of office, family behavioral health counseling and therapy with client present, per 15 minutes	HR	12, 99
H0004	Out of office, family behavioral health counseling and therapy without client present, per 15 minutes	HS	12, 99
H0004	Office, individual behavioral health counseling and therapy, per 15 minutes		11, 22, 50, 53, 72
H0004	Office, family behavioral health counseling and therapy with client present, per 15 minutes	HR	11, 22, 50, 53, 72
H0004	Office, family behavioral health counseling and therapy without client present, per 15 minutes	HS	11, 22, 50, 53, 72
H0004	Office, group behavioral health counseling and therapy, per 15 minutes	HQ	11, 22, 31, 32, 33, 50, 53, 72, 99

Code	Description	Mod.	Place of Service
Codes to be Reviewed for April, May & June Dates of Service			
Support Services (continued)			
T1019	Personal care services, per 15 minutes (not for inpatient or residential care facilities		04, 11, 12, 20, 50, 53, 71, 72, 99
T1020	Personal care services, per diem (not for inpatient or residential care)		11, 12, 50, 53, 71, 72, 99
Crisis			
S9484	Crisis intervention mental health service, per hour		21, 51, 99
S9485	Crisis intervention mental health services, per diem		21, 51, 99
H2011	Crisis intervention service, per 15 minutes		04, 11, 12, 20, 23, 50, 53, 71, 72, 99
H2011	Crisis intervention service via 2 person team, per 15 minutes	HT	04, 11, 12, 20, 23, 50, 53, 71, 72, 99

Attachment 2

RBHA Quarterly Data Validation Study Results

Review Period:

RBHA: GSA: Date of Review:

Provider Name & ID: Date of Exit Interview:

Provider's Score: Date Final Report Sent:

Client Name & ID	# of Services Reviewed	Number of Errors by Type			Action taken by RBHA	Provider Follow-up	Did DBHS Attend Y/N
		Omission	Correctness	Timeliness			

Division of Behavioral Health Services
Bureau of Financial Operations

150 N. 18th Avenue, Suite 200
Phoenix, Arizona 85007-3228
(602) 364-4558
(602) 364-4736 FAX

JANET NAPOLITANO, Governor
SUSAN GERARD, Director

[Date]

[Recipient/Title]
[RBHA or Agency]
[Street Address]
[City, State Zip]

Dear [Mr./Ms.] [Recipient]:

The Division of Behavioral Health Services, Office of Program Support (DBHS/OPS) has received and reviewed [RBHA's] Data Validation Quarterly report for the quarter ending [Month Day, Year]. [RBHA] has received a score of [Percentage] which represents a rating of [score] compliance.

[RBHA] is required to perform on-site data validation reviews of their providers in accordance with the requirements outlined in the Office of Program Support Manual. In addition the quarterly reports will be reviewed and the findings will be used in scoring the Data Validation Administrative Review standard. The score is determined by dividing the number of yes answers by 10 (the total number of requirements). The attached table reflects the results of the DBHS/OPS review:

[Identify any changes/corrections required of the RBHA (i.e. ADHS/DBHS requires that the submission of future Quarterly Reports contain a copy of the sign in sheet and a brief summary of the training content. In addition the RBHA should include provider follow-up omission/correctness errors that contain the date the errors were corrected and the ICN of the corrected encounter(s)].

Should you have any questions regarding this matter or need additional assistance, please contact [Name and phone number of Data Validation Specialist]

Sincerely,

Kayla Caisse
Data Validation Manager

c: [RBHA CFO and/or other identified RBHA Staff], [RBHA]
Terri Speaks, ADHS
Kevin Gibson, ADHS
Contract Compliance File

Error Rate Monitoring

Introduction:

The purpose of the data validation ride-along is to evaluate the process of the RBHA to ensure they are accurately and thoroughly performing their data validation studies. Additionally, it is an opportunity for DBHS/OPS to perform a quarterly provider data validation study with the RBHAs similar to the yearly AHCCCS study. The error rate monitoring reports will be scored as part of the RBHA's yearly Administrative Review.

After the Ride-Along:

Within five business days after the ride-along, the Data Validation Unit will prepare and issue a summary of the ride-along, which will include the number of records reviewed, the number of errors found, the review score, any training issues identified, and if required, requests for corrective action. DBHS will give the RBHA a date by which the omission errors must be submitted. The RBHA will also be required to correct and resubmit the correctness errors by that same date. Correctness errors include diagnosis code errors.

Type of Error	Number Reviewed	Number of Errors	Error Rate
Correctness: Service Code			
Correctness: Modifier			
Correctness: Place of Service			
Correctness: Units			
Correctness: Diagnosis Code			
A single encounter may have more than one correctness error, however the encounter will only be counted once in the total calculation			
Timeliness			
Omission			
	Encounter Total	**Encounters w/Errors**	**Error Rate**
Total			

In the event any one provider has an error rate greater than 10%, the RBHA is required to submit an implementation plan for that provider and perform a second data validation study for that provider within six months. After completion of the follow-up study, the RBHA will provide DBHS with documentation of the findings.

Implementation Plan:

The RBHA is required to respond to DBHS/OPS within 10 business days from the date of the Ride-along letter with an implementation plan on any review with an error rate greater then 10%. The implementation plan must include the following:

- The date the follow-up Data Validation study will be performed
- The date error correction will be completed-the RBHA will provide DBHS/OPS with ICNs when the errors have been corrected
- The date omissions will be submitted-the RBHA will provide DBHS/OPS with the ICNs of the submitted encounters
- The date non-billable/non-documented services will be voided from the RBHA's system and CIS-the RBHA will provide DBHS/OPS with ICNs of the voided encounters
- The date training will be provided-the RBHA will provide DBHS/OPS with a copy of the sign-in sheet and a brief summary of the training content.

Monitoring

After the letter is sent to the RBHA the Data Validation Representative will enter the following information in the *Completed Data Validation Ride-Alongs* log found at M:\Program Support Staff\Data Validation.

- Name of provider reviewed
- RBHA/GSA
- State Fiscal Year Quarter when the review was performed
- Error Rate
- Date the Implementation Plan is due from the RBHA

Completed Data Validation Ride-Alongs

Provider	RBHA	Quarter	Date	Error Rate	Date Plan Expected	Status/ Date	Date Corrections Expected	Encounters Corrected in CIS	Date of Follow-Up Audit

Implementation Plan Received:

After the Implementation Plan is received from the RBHA the Data Validation Representative will validate the following:

- Did the RBHA identify the date the follow-up Data Validation study will be performed?
- Did the RBHA identify the date error correction will be completed?
- Did the RBHA identify the date omissions will be submitted?

- Did the RBHA identify the date non-billable/non-documented services will be voided from the RBHA's system and CIS?
- Did the RBHA identify the date training will be provided?
- Are the dates provided within 30 days from the date of the original letter?

Implementation Plan Complete/Accepted

If the information provided is complete the Data Validation Representative will notify the RBHA within 5 business days of acceptance (Attachment 1). The Data Validation Representative will update the *Completed Data Validation Ride-Alongs* log with the Implementation Plan status and the date corrections are expected.

Implementation Plan Received/Incomplete

If the information provided is incomplete or not specific the Data Validation Representative will notify the RBHA within 5 business days that a revision is required (Attachment 2). The RBHA will have 10 business days from the date of the second letter to submit a revised implementation plan. The Data Validation Representative will update the *Completed Data Validation Ride-Alongs* log with the Implementation Plan status and the new expected receipt date for the plan. When the revised plan is received and accepted the Data Validation Representative will follow the guidelines listed above for an accepted implementation plan.

Implementation Plan Not Received

If OPS has not received the RBHA's implementation plan by COB on the due date the Data Validation Representative will send the RBHA an e-mail the next business day requesting a status. If there is no response to the e-mail or the implementation plan is not received by the promised date the Data Validation Representative will send a letter to the RBHA requesting the plan (Attachment 3). The RBHA will be given 5 days to submit the requested implementation plan or further action will be taken. In addition, the Data Validation Representative will update the *Completed Data Validation Ride-Alongs* log with the Implementation Plan status and the new expected receipt date for the plan.

Maintaining *Completed Data Validation Ride-along* log:

It is the OPS Data Validation Specialist's responsibility to update and maintain the *Completed Data Validation Ride-Along* log.

Administrative Review Scoring:

RBHA Quarterly reports and follow-up after ride-alongs are monitored as part of the RBHA's yearly administrative review. Complete information regarding the scoring of Administrative Review standards can be found in the Administrative Review Section of this manual.

Attachment 1

Division of Behavioral Health Services
Bureau of Financial Operations

150 N. 18th Avenue, Suite 200
Phoenix, Arizona 85007-3228
(602) 364-4558
(602) 364-4736 FAX

JANET NAPOLITANO, Governor
SUSAN GERARD, Director

[Date]

[Recipient/Title]
[RBHA or Agency]
[Street Address]
[City, State Zip]

Dear [Mr./Ms.] [Recipient]:

The Division of Behavioral Health Services, Office of Program Support (DBHS/OPS) has received and reviewed [RBHA's] implementation plan for the Ride-Along for [Provider] that took place on [Month Day Year]. DBHS/OPS appreciates your timely submission of the required Implementation Plan.

Your Implementation Plan for [Provider] has been accepted. The corrections addressed need to be submitted to DBHS/OPS by [the date provided by the RBHA].

[RBHA] will be responsible for informing DBHS/OPS when the encounters have been submitted either via e-mail or letter. [RBHA] will also submit the corrected ICN's for the encounters to DBHS/OPS.

DBHS/OPS may attend the follow-up Data Validation Audit for [Provider]. If DBHS/OPS attends the follow-up Data Validation Audit, the DBHS Data Validation Specialist will notify the [RBHA] via telephone call or e-mail.

Should you have any questions regarding this matter or need additional assistance, please contact [Name and phone number of Data Validation Specialist].

Sincerely,

[Name]
[Data Validation Specialist]

c: [RBHA CFO and/or other identified RBHA Staff], [RBHA]
[Name] OPS Manager, ADHS
[Name] Eligibility/Encounter Manager, ADHS
[Name] Data Validation Manager, ADHS
Contract Compliance File

Attachment 2

Division of Behavioral Health Services
Bureau of Financial Operations

150 N. 18th Avenue, Suite 200
Phoenix, Arizona 85007-3228
(602) 364-4558
(602) 364-4736 FAX

JANET NAPOLITANO, Governor
SUSAN GERARD, Director

[Date]

[Recipient/Title]
[RBHA or Agency]
[Street Address]
[City, State Zip]

Dear [Mr./Ms.] [Recipient]:

The Division of Behavioral Health Services, Office of Program Support (DBHS/OPS) has received [RBHA's] implementation plan regarding the Ride-Along for [Provider] that took place on [Month Day Year].

Your Implementation Plan for [Provider] has been reviewed and found to be unsatisfactory. DBHS/OPS requests that [RBHA] submit a revised Implementation Plan for [Provider] within 10 business days of receiving this letter. The revised Implementation Plan must include the following points:

[Enter specific bullets as required]

- Date when the correction of billing errors will be complete
- Date when the submission of omissions will be complete
- Date when the voiding of non-billable services from RBHA's system and CIS will occur
- Date when the services not documented in the chart will be voided from RBHA's system and CIS or submission of proof of service
- Date the follow-up Data Validation Study for the [Provider] will occur

Should you have any questions regarding this matter or need additional assistance, please contact [Name and phone number of Data Validation Specialist]

Sincerely,

[Name]
Data Validation Specialist

C: [RBHA CFO and/or other identified RBHA Staff], [RBHA]
[Name] OPS Manager, ADHS
[Name] Eligibility/Encounter Manager, ADHS
[Name] Data Validation Manager, ADHS
Contract Compliance File

Attachment 3

Division of Behavioral Health Services
Bureau of Financial Operations

150 N. 18th Avenue, Suite 200
Phoenix, Arizona 85007-3228
(602) 364-4558
(602) 364-4736 FAX

JANET NAPOLITANO, Governor
SUSAN GERARD, Director

[Date]

[Recipient/Title]
[RBHA or Agency]
[Street Address]
[City, State Zip]

Dear [Mr./Ms.] [Recipient]:

The Division of Behavioral Health Services, Office of Program Support (DBHS/OPS) has not yet received the implementation plan for the Ride-Along that took place on [Month Day Year] for the [Provider].

[RBHA] is required to submit to DBHS/OPS an Implementation Plan for the Ride-Along that took place on [Month Day Year] for the [Provider] by [Exact Date 5 business days] upon receiving this letter. If the aforementioned letter is not received by DBHS/OPS by the due date it is within the realm of DBHS/OPS to seek action against [RBHA].

[RBHA] Implementation Plan must contain the following:

- Correction of billing errors
- Submission of omissions
- Voiding of non-billable services from RBHA's system and CIS
- Voiding of services not documented in the chart from RBHA's system and CIS or submission of proof of service
- Date of follow-up Data Validation Study for [Provider]

It is imperative [RBHA] submit the outline and implementation for the Corrective Action Plan as it is stated in the guidelines set by DBHS/OPS for the Data Validation Ride-Along process.

Should you have any questions regarding this matter or need additional assistance, please contact [Name and phone number of Data Validation Specialist]

Sincerely,

[Name]
Data Validation Specialist

c: [RBHA CFO and/or other identified RBHA Staff], [RBHA]
[Name] OPS Manager, ADHS
[Name] Eligibility/Encounter Manager, ADHS
[Name] Data Validation Manager, ADHS
Contract Compliance File

AHCCCS Study

Introduction:

The Centers for Medicare and Medicaid Services (CMS) requires AHCCCS to oversee and submit progress reports on the encounter data collection process. AHCCCS performs yearly data validation studies to meet this requirement. All AHCCCS contractors and subcontractors are contractually required to participate in this process. In addition to meeting the CMS requirement, the data validation studies enable AHCCCS to monitor and improve the quality of encounter data.

Sample Selection Process:

The sample size for each contractor is re-calculated each year. The size is determined using the detailed "Random Sample Calculation" methodology documented in the *AHCCCS Encounter Data Validation Technical Document*. The sample size indicates the number of encounters/services AHCCCS intends to review for the data validation study.

Medical Record Collection Process:

AHCCCS creates a report for each RBHA identifying the clients selected for review. The Data Validation Specialist will send the RBHA the appropriate portion of the report and a computer disk that identifies the clients that are included in the data validation study. The RBHA is responsible for identifying which provider/facility provided the services to the client and where the medical records are housed. The RBHA must forward the list of providers/facilities to AHCCCS by the date specified. AHCCCS will prepare a letter to notify the provider about the data validation process and its requirements. The provider/facility must locate the medical records for each of the clients requested and must forward the medical records to AHCCCS by the date specified.

Type of Errors Examined:

AHCCCS will review the medical records to determine what services the clients received. The services received will be compared to the encounters submitted to determine what types of errors, if any, exist. To comply with CMS requirements three types of errors are examined.

- Correctness-an error is assessed when the dates of service, procedure code and or diagnosis code in the encounter were incorrectly coded according to the medical documentation
- Timeliness- an error is assessed when the encounter is received by AHCCCS more than 240 days from the end of the month in which the service was rendered, or the effective date of the enrollment
- Omission- an error is assessed when provider documentation indicates that medical services were rendered, but an encounter was never received at AHCCCS

Preliminary Report Distribution, Review and Challenge

A preliminary report will be prepared and will be distributed to each RBHA. This is the only opportunity that the RBHA/provider has to challenge the errors identified by AHCCCS. The RBHA is responsible for identifying any errors that they want to challenge in the AHCCCS preliminary report. The RBHA should review the preliminary error report and perform a comparison to data from the client's medical records and/or the RBHA's system. Each challenge must be supported by additional documentation. Types of additional documentation include, but are not limited to:

- PMMIS screen prints
- CIS screen prints
- Screen prints from the RBHA's internal system

All documentation required to support the challenge including the *Data Validation Challenge Form* (Attachment 1) must be submitted to OPS by the date specified. If the documentation does not support the challenge, the challenge will not be processed and forwarded to AHCCCS.

Methods for Challenging Errors:

The type of evidence that is required to successfully challenge an error is dependent on the type of error identified. This section describes some the techniques that may be useful in challenging data validation errors.

Remember: This is the <u>ONLY</u> opportunity for the RBHA to challenge the errors identified by AHCCCS.

<u>Correctness Errors</u>-The RBHA or the provider must:

- Submit documentation outside of the medical record supporting that the code or date on the encounter is the clinically correct code or date
- Show that the ICD9 diagnosis code in question did not require a 4^{th} or 5^{th} digit at the time the service was provided

<u>Timeliness Errors</u>-The RBHA or the provider must:

- Document that the encounter could not be submitted in a timely fashion at AHCCCS because of system problems at AHCCCS during the relevant timeframe.
- Show that the encounter referenced is an adjustment and that the original encounter and the adjustment were both submitted in the correct time frame.

<u>Omission Errors</u>-The RBHA or the provider must document that the encounter should never have been sent to AHCCCS because:

- The client was not eligible for Title XIX or XXI services
- The service was not covered by AHCCCS
- The provider was not eligible to bill for Title XIX or XXI services

Challenge Received:

The Data Validation Unit will review the preliminary report and the challenges submitted by the RBHAs. The Data Validation Unit will create one unified challenge response containing all documented challenges noted by the RBHA. This along with all the supporting documentation submitted by the RBHAs, will be forwarded to AHCCCS.

Final Report:

AHCCCS will review the challenges and documentation submitted. This review will result in a final report that is distributed to the appropriate RBHA. Included with the final report is the sanction assessed by AHCCCS. The AHCCCS sanction calculation process is a complex, multi-step process. Details regarding the AHCCCS sanction calculation process can be found in the *AHCCCS Encounter Data Validation Technical Document.* The ADHS/DBHS process for passing the AHCCCS Sanction on to the RBHA is as follow, ADHS/DBHS takes the total sanction dollar amount and divides it by the total number of errors from AHCCCS, which results in a sanction amount per error. The sanction amount per error is then multiplied by the number of errors for each RBHA resulting in a final sanction amount per RBHA. This process is valid for both the "A" and "B" Study.

Collection of Sanction:

ADHS/DBHS will withhold the final sanction amount from the capitation paid to the RBHA each month.

Attachment 1

Arizona Department of Health Services
Division of Behavioral Health Services
Office of Program Support Services
150 N. 18th Avenue, Suite 200
Phoenix, Arizona 85007
Phone: (602) 364-4731
Fax: (602) 364-4736

Data Validation Challenge

Preliminary Results are the RBHAs Only Opportunity to Challenge the AHCCCS Data Validation Findings

RBHA: ☐ Centpatico2 ☐ Centpatico4 ☐ NARBHA ☐ ValueOptions ☐ CPSA3 ☐ CPSA5

RBHA Representative: _____ **Phone:** _____

Client Information:

Client Name: _____

CIS Client ID: _____ AHCCCS Client ID: _____

Challenged Error:

☐ Omission ☐ Correctness ☐ Timeliness

AHCCCS Tracking #: _____

CIS ICN: _____ AHCCCS CRN: _____

Explanation of Challenge: _____

Please note: Without proper and legible documentation attached the challenge will not be forwarded to AHCCCS and the challenge will be considered unsubstantiated.

Required Documentation:

☐ CIS Screen Print ☐ PMMIS Screen Print ☐ RBHA Internal Screen Print ☐ Other Information as Needed to Support Claim

For ADHS Use Only: ADHS Reviewer: _____

☐ Challenge Referred to AHCCCS
☐ Challenge Determined to be BHS Responsibility
☐ Challenge Determined to be RBHA Responsibility

Date: _____

Comment: _____

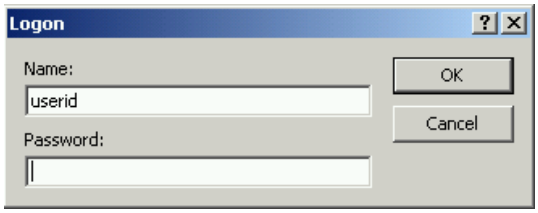
System Service Requests

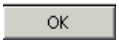
Introduction:

A System Service Request (SSR) is the method used by the Office of Program Support (OPS) to notify DBHS/ITS of system changes/modifications needed in the Client Information System (CIS). In addition an SSR can be used to request research of encounter issues or to request reports.

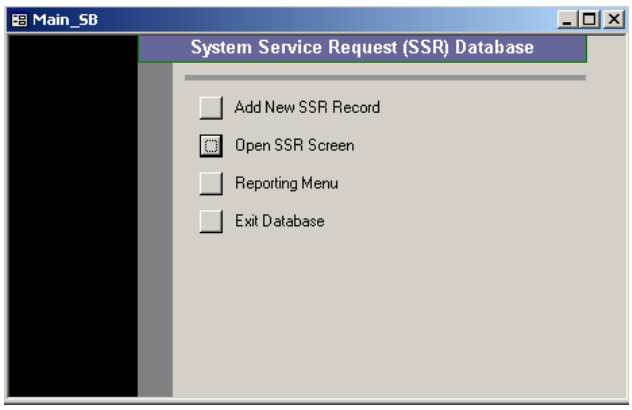
Create an SSR:

OPS staff can access the SSR database using the following icon found on their desktop. The user ID and Password will then be entered.



1) Type in your **User ID** and **Password**. (*Note: User IDs and passwords are case sensitive*)
2) Press the **OK** button. 

SSR Main Menu

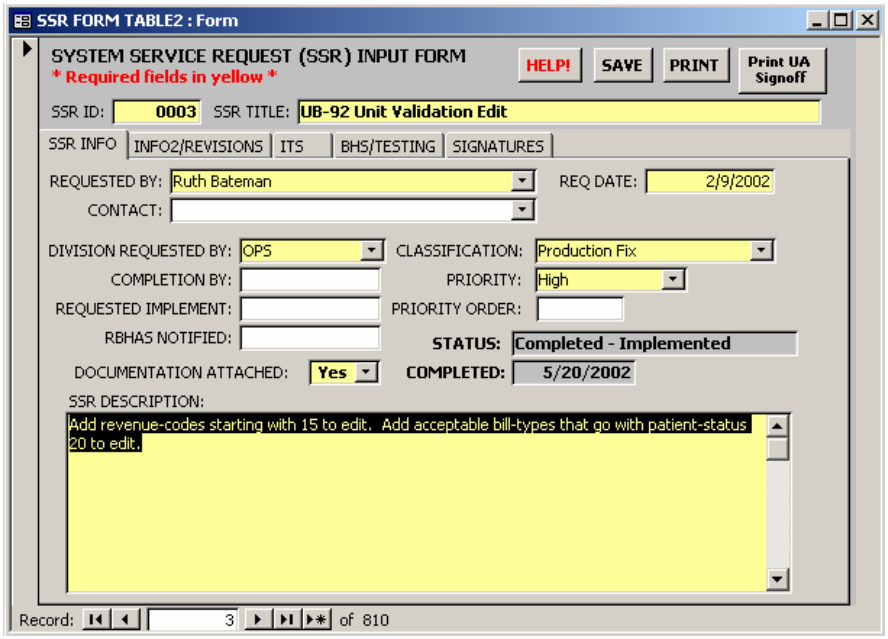


- **Add New SSR Record** – Open SSR Input Screen to enter a new SSR
- **Open SSR Screen** – Open SSR Input Screen to view all existing SSRs
- **Reporting Menu** – Go to Report Menu
- **Exit Database** – Exit system

Adding a New SSR Record

The following information is to be completed to add a new or change an existing SSR.

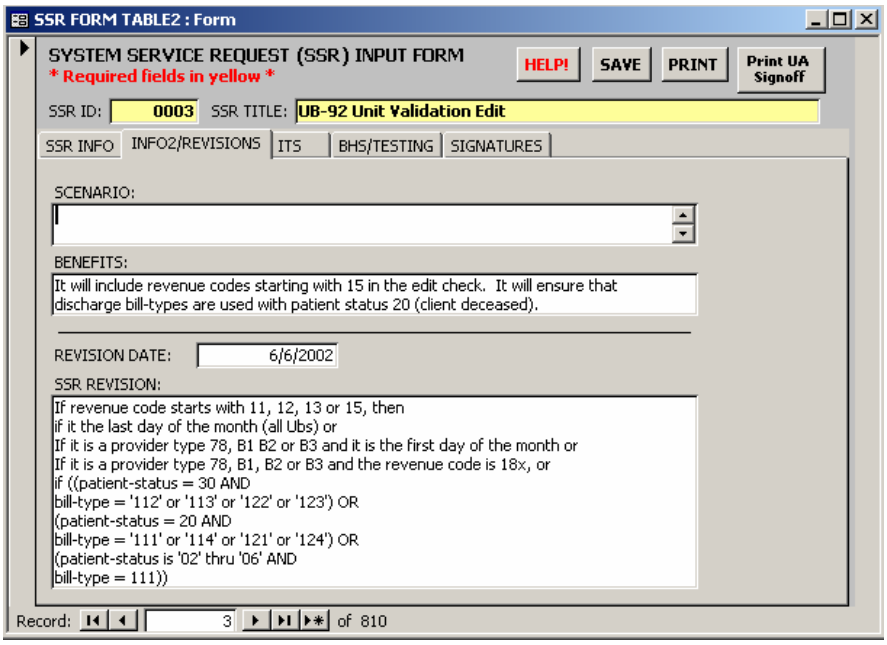
SSR INFO TAB



***Note*: Required fields are in yellow.**

- **SSR ID** – Number automatically generated by SSR database
- **SSR TITLE** – Brief description of request
- **REQUESTED BY** - Name of requester + **DATE** - Date request was created
- **CONTACT** – Contact for questions regarding the request, if different from the Requester
- **DIVISION REQUESTED BY** - Requester's Division (pull down list)
- **COMPLETION BY** - If applicable, date the request needs to be completed
- **REQUESTED IMPLEMENTATION** - If applicable, requested date for implementation
- **RBHAS NOTIFIED** - If applicable, date RBHAs were notified of change
- **DOCUMENTATION ATTACHED** - Yes/No (default = "No")
- **CLASSIFICATION** - Type of request (pull down list, default = "Enhancement")
- **PRIORITY** - Requester's priority for request (pull down list, default = "Normal")
    - *Emergency*: Agency services immediately negatively affected
    - *High*: Important to Agency/Division - Complete after any emergencies
    - *Normal*: Change request will increase production - Complete as scheduled
- **PRIORITY ORDER** - Order in which requests will be prioritized and worked
- **STATUS** - Status of request (read-only, see ITS Tab to edit this field)
- **COMPLETED** - Date request was completed (read-only, see ITS Tab to edit this field)
- **SSR DESCRIPTION** - Detailed description of request

INFO2/REVISIONS TAB



- **SCENARIO** - A descriptive example of the problem or change
- **BENEFITS** - A description of any/all benefits of the request
- **REVISION DATE** - Date of revision (*Note: If there are multiple revisions, note the revision date for each one in the SSR Revision description field*).
- **SSR REVISION** - If applicable, a description of change to original request

After the SSR form has been completed it must be signed by the OPS Manager or the DBHS CFO.

Distribution of an SSR:

After an SSR is written and the originator has obtained all of the required signatures the SSR is placed in the designated Administrative Staff's In-Basket. The Administrative Staff will then:

- Make 2 copies of the SSR including any attached documentation
- Hand deliver the original SSR including all attached documentation to the IT department
- Deliver one copy including documentation to the SSR Originator
- The remaining copy will be used to create a testing folder which will be delivered to the Testing Unit.

It is the responsibility of the SSR Originator to follow-up on the progress/completion of the SSR request

Training Requirements

Introduction:

RBHAs are required to provide on-going training to their providers for submission of claim/encounter/demographic data.

Encounter Related Training:

The OPS Encounter Unit requires the RBHAs to provide evidence of on-going training that has been provided to their providers. The following evidence will be submitted at the OPS/RBHA Workgroup Meeting:

- Sign-in sheets for any training that took place in the previous month
- A brief description of the training provided

Data Validation Related Training:

The OPS Data Validation Unit requires the RBHA to provide training to any provider with a data validation review error rate greater than 10%. The following evidence will be submitted with each Quarterly Data Validation Report:

- Sign-in sheets for any training that took place in the previous quarter
- A brief description of the training provided

T/RBHA Administrative Review

Introduction:

Annually the ADHS/DBHS/OPS conducts an Administrative review of each RBHA. Monitoring and Scoring of the Administrative Review Standards is performed throughout the review year based on the following established policies/procedures.

Standard:

The RBHA has a Data Validation Review process to ensure that all providers are submitting accurate, complete and timely claims for all services performed and corrects errors identified in the Data Validation process in a timely manner.

Scoring:

Did RBHA Meet On-site Requirement	**Yes/No**
RBHA submitted Quarterly Report by 15th	
RBHA submitted the report in the proper format with all required fields	
RBHA Reviewed 10% of provider network	
RBHA reviewed records for omissions	
RBHA reviewed records for timeliness	
RBHA reviewed records for correctness	
RBHAs actions are specific	
RBHA performed exit interview with provider at the end of every review	
RBHA sent provider report of review findings within 10 days of review	
Divide total yes answers by total possible (9) to get score.	Score:

RBHA submitted/corrected encounters in error in a timely manner:

For the Administrative Review period, each Ride-along worksheet will be reviewed to determine the number of errors/omissions that have been corrected. A percentage will be determined by dividing the total number of errors corrected by the total number of errors. The two percentages will be added together and divided by two to acquire the final percentage, which will be scored against the standard Admin Review scale:

Score	Rating
90-100%	Full Compliance
75-89%	Substantial Compliance
50-74%	Partial Compliance
0-49%	Non Compliance

Standard:

The RBHA ensures that FFS claims are accurately encountered to ADHS/DBHS.

Scoring:

The score for this standard reflects the score from the Office of Program Support's FFS Check Register Reviews for the average of all quarters reviewed and scored during FY 07.

For the Admin Review period, each RBHA should have completed four separate FFS Check Register Reviews with four separate percentages. All four of the percentages will be added together and divided by four to acquire the final percentage, which will be scored against the standard Admin Review scale:

90 – 100%	Full Compliance
75 – 89%	Substantial Compliance
50 – 74%	Partial Compliance
0 – 49%	Non-Compliance

Standard:

The T/RBHA submits complete, accurate and timely intake and demographic information

Scoring:

There are two elements that apply when evaluating the final score for meeting demographic data processing requirements defined by ADHS: the percentage of timely demographic submissions and the percentage of complete/accurate demographics during the review period. Here is how each element is rated:

- **90% Accuracy /Completeness**

  The total of all demographics accepted / the total amount of all demographics submitted = percentage

  -If the percentage is 90% or above Score = 100%
  -If the percentage is below 90% Score = 0%

- **Timeliness**

  (This element's scoring will be based on the 7 Report [Initial Demographic] provided by Quality Management.)

  The total number of demographics > 55 days / the total number of demographics = percentage

The percentages from both elements will be added together and then divided by two, resulting in the final percentage that will be scored against the standard Admin Review scale:

90 – 100%	Full Compliance
75 – 89%	Substantial Compliance
50 – 74%	Partial Compliance
0 – 49%	Non-Compliance

Standard:

The RBHA has developed and maintained a system that meets claims/encounter data processing requirements defined by ADHS/DBHS.

Scoring:

There are four elements that apply when evaluating the final score for meeting claims/encounter data processing requirements defined by ADHS: Meeting a 90% Acceptance Rate, meeting performance measured by the 210 Report, meeting the RBHA's submission schedule and meeting performance measured by the Aged Pends Report. Here is how each element is rated:

- **90% Acceptance**

The total number of all encounters accepted / the total amount of all encounters submitted = passing/failing percentage

- If the final percentage is 90% or above Score = 100%
- If the final percentage is below 90% Score = 0%

- **210 Report**

The total amount 210 PD / the total amount of encounters accepted = percentage

Take the percentage and subtract by 100 to receive the final score

- **Submission Schedule**

Each RBHA should have 12 months worth of submission data to review for the Admin Review period (7/1/06 – 6/30/07). If a RBHA does not meet it's predetermined submission schedule, for any one of the three form types, within a month, it will be determined that the RBHA has not met the requirements of it's submission schedule.

There are 12 possible points a RBHA can obtain. Each month the RBHA meets it's submission schedule requirements; 1 point will be awarded. Each month the RBHA fails to meet it's submission schedule requirements; 0 points will be awarded.

The total points awarded / total months = percentage

(12/12) = 100%
(11/12) = 92%
(10/12) = 83%

(9/12) = 75%
(8/12) = 67%
(7/12) = 58%
(6/12) = 50%
(5/12) = 42%
(4/12) = 33%
(3/12) = 25%
(2/12) = 17%
(1/12) = 8%
(0/12) = 0%

- **Aged Pends**

The total number of pends > 120 days / the total number of pends = percentage

Take the percentage and subtract from 100 to receive the final percentage for this element

Each element should now have its own percentage. Add all acquired percentages together and then divide by 4 (the sum of all the elements). This will result in the final percentage, for this standard, which should be scored against the standard Admin Review scale:

90 – 100%	Full Compliance
75 – 89%	Substantial Compliance
50 – 74%	Partial Compliance
0 – 49%	Non-Compliance

Standard:

The RBHA submits an accurate and timely override/deletion log from providers to the RBHA and for encounters from the RBHA to ADHS/DBHS in accordance with OPS submission schedule.

There are two elements applied to the evaluation of the final scoring of the Administrative Review standard: timeliness and accuracy. The RBHA must submit the override/deletion log by the OPS requested deadline and the file must be formatted according to specifications of the file layout. Each RBHA should have submitted four override/deletion logs during the review period.

- The RBHA submitted all four Override/Deletion logs timely and accurately – 100% (Full Compliance)
- The RBHA submitted three out of the four Override/Deletion logs timely and accurately – 89% (Substantial Compliance)
- The RBHA submitted two out of the four O/D logs timely and accurately – 74% (Partial Compliance)
- The RBHA submitted one out of the four O/D logs timely and accurately – 49% (Non-Compliance)
- None of the O/D logs submitted by the RBHA were timely and accurate – 0% (Non-Compliance)

AHCCCS Operational and Financial Review

Annually, AHCCCS will conduct an Operational and Financial Review (OFR) of DBHS in order to determine if there are organization, management and administrative systems in place capable of fulfilling all contract requirements including those areas related to encounter submission and data validation.

System Access Requests

Introduction:

Some T/RBHA employees will need access to the DBHS/CIS and AHCCCS/PMMIS claim systems to perform their job duties. The procedures to obtain a CIS and/or PMMIS ID are as follows:

CIS

Two forms must be completed to request a CIS user ID. The employee requesting the login ID must complete and sign both forms. To obtain copies of the CIS forms the RBHA should contact the ADHS/DBHS Corporate Compliance Office.

- ADHS Computer User Registration Request Form (Attachment 1)
- ADHS User Affirmation Statement (Attachment 2)

The T/RBHA should fax both signed forms to the ADHS/DBHS Corporate Compliance Office at fax number (602) 364-4736. The Corporate compliance Officer will review the forms to ensure they are complete and will forward the request to the IT department. ADHS/DBHS ITS will assign an appropriate login ID and password for the new user.

PMMIS

Two forms must be completed to request a PMMIS user ID. The employee requesting the login ID must complete and sign both forms. The RBHA may obtain copies of the AHCCCS security forms at the following website:
http://www.ahcccs.state.az.us/Publications/Forms/PlansProviders/02-001F.doc

- AHCCCS User Access Request Form (Attachment 3)
- AHCCCS User Affirmation Statement (Attachment 4)

The T/RBHA should fax both signed forms to the ADHS/DBHS Corporate Compliance Office at fax number (602) 364-4736. The Corporate compliance Officer will review the forms to ensure they are complete and will forward the request to AHCCCS. AHCCCS will assign an appropriate login ID and password for the new user.

Attachment 1

ADHS COMPUTER
USER REGISTRATION REQUEST FORM

MAIL TO: *Security Administration, ITS, 1740 W. Adams, Phoenix, 85007*
FAX #: *(602) 542-1235* **E-MAIL**: *SECURITY* **PHONE #**: *(602) 542-2810*

*** TO BE COMPLETED BY AUTHORIZED REQUESTOR ***

Please ☐ Add ☐ Remove ☐ Change *Request Date:* _____ *Effective Date:* _____

Last Name _____ First Name _____ MI _____ Working Title _____
(PRINT)

Office/Section _____ Physical Location _____ Phone _____

On the following systems/applications:

LANS = ☐ ACPTC ☐ HSP1 ☐ HSP2 ☐ BHS1 ☐ DHS1 ☐ EDC1
☐ EMS1 ☐ FHS1 ☐ FLG1 ☐ ITS1 ☐ LAB0 ☐ LAB1
☐ PHS1 ☐ TUC1 ☐ VRS1

NT Servers = ☐ BHSNT

OTHER = ☐ Internet

ALS = ☐ AMS ☐ CTS
BEMS = ☐ AMB ☐ EMP ☐ EMT
BHS = ☐ CIS ☐ OGA ☐ OHR Adhoc = (☐ CIS ☐ OGA ☐ OHR)
☐ IRS ☐ IRS
CFHS = ☐ CRS ☐ CATS ☐ CATS Claims ☐ Hlth Start ☐ Sensory
DIR = ☐ ODS
EDC = ☐ ASIIS ☐ BDR ☐ STD
FIN SVCS = ☐ AEDW ☐ EPR ☐ POTSY ☐ PPTS ☐ Supply
{DOA} ☐ USAS ☐ HRMS ☐ Fix asset ☐ Dataqry Acct: _____
PHS = ☐ Birth ☐ Death ☐ ATS
SLS = ☐ CLAS ☐ RLIMS ☐ ELBIS ☐ LITS ☐ CLIA
ITS = ☐ Unix ☐ AppWorx
ORACLE: ☐ asit ☐ tw ☐ cist ☐ crst ☐ natt ☐ vrst
☐ asip ☐ pw ☐ cisp ☐ crsp ☐ natp ☐ vrsp

Other Instructions: _____

Supervisor (PRINT): _____

Supervisor Signature: _____ *Phone:* _____

Data Owner Signature: _____ *Phone:* _____

Office: _____

*** TO BE COMPLETED BY THE ADHS SECURITY ADMINISTRATOR ***

Completed Date: ____/____/____

The following has been: ☐ Added ☐ Removed ☐ Changed

Login ID _____ Internet ID _____ LAN _____

Comments: _____

Signed: _____
Security Administrator

\Common_MS\Forms\NewUser\User_reg - Edoc rev 09/03/2003

ADHS COMPUTER
USER REGISTRATION REQUEST FORM
INSTRUCTIONS

I. Fill out the top part of the form per the following instructions:

Add/Remove/Change	-	Check one of the boxes to indicate which action is needed. *{Required Field}*
Request Date	-	Enter the date this form is being filled out. (i.e. NOW) *{Required Field}*
Effective Date	-	If request is NOT to be done within 2 days, enter the date the requested action is needed. If blank, the request will be done within 2 days.
User Name	-	PRINT the complete name. (Last Name, First Name, and Middle Initial) User Name
Work. Title	-	Enter the working title of user. If the user is an outside consultant, write CONSULTANT in this space. *{Required Field}*
Office/Section	-	Enter the name of the office AND section where the user works. *{Required Field}*
Physical Location	-	User's work location. *{Required Field}*
Phone#	-	Enter the phone number of the user. *{Required Field}*
Appl/Systems	-	If this form is being filled out for a client user (i.e. non-ITS employee) check off only the particular application(s) (i.e. BDR, CLAS, USAS), into which the user needs to be added or removed. If this form is being filled out for ITS personnel who need general access to a computer system, also check those systems.
Other Instr	-	Write any other specific instructions the Security Administrator will need to know
Supvr. Name	-	PRINTED Supervisor Name. *{Required Field}*
Supvr. Signature	-	Supervisor's signature ONLY! Forms with any other signature will not be processed. *{Required Field}*
Phone#	-	Enter the phone number where the Supervisor can be reached if there are any questions. *{Required Field}*
Data Owner Sign.	-	Signature of the Person, or their designee, responsible for the data for which access is being requested
Phone#	-	Enter the phone number where the Data Owner can be reached if there are any questions
Office	-	Enter the name of the office where the Data Owner works.

II. Mail, hand deliver, E-MAIL, or FAX this request to the Security Administrator. (The mail address, E-MAIL name, and FAX # are at the top of the request form.) The request will be processed within 48 hours after being received.

(EXCEPTION: If a user needs to be <u>immediately</u> removed from the system, call the Security Administrator to facilitate special processing requirements.)

III. When the request has been processed, a copy of the completed form showing the login name and Internet ID, (if applicable), will be returned to the requestor by Inter-office Mail. Each new user added will also receive in a sealed envelope, their own unique USERID and INITIAL password.

Attachment 2

ARIZONA DEPARTMENT OF HEALTH SERVICES
USER AFFIRMATION STATEMENT

I have been made aware and understand that all personnel who have access to the Arizona Department of Health Services (DHS) data are bound by applicable laws, rules and DHS directives and are responsible for DHS data.
I agree to abide by all applicable laws, rules and DHS directives, and I pledge to refrain from any and all of the following:

1. Revealing DHS data to any person or persons outside or within DHS who have not been specifically authorized to receive such data.

2. Attempting or achieving access to DHS data not germane to my mandated job duties.

3. Entering/altering/erasing DHS data for direct or indirect personal gain or advantage.

4. Entering/altering/erasing DHS data maliciously or in retribution for real or imagined abuse, or for personal amusement.

5. Using DHS workstations, printers, and/or other equipment for other than work related purposes.

6. Using another person(s) personal logon ID and password.

7. Revealing my personal logon ID and password to another person.

8. Asking another person to reveal his/her personal DHS logon ID and password.

In relation to my responsibilities regarding the proprietary rights of the authors of computer software utilized by DHS, I recognize that:

1. DHS licenses the use of computer software from a variety of outside companies. DHS does not own this software or its related documentation and, unless authorized by the software developer, does not have the right to reproduce it.

2. When used on a local area network or on multiple machines, employees/contractors shall use the software in accordance with the license agreement.

3. Employees/contractors who know of any misuse of software or related documentation within the agency shall notify their manager/supervisor, or the department security administrator.

4. Employees/contractors making, acquiring or using unauthorized copies of computer software, or using personal non-DHS software are subject to punitive action in accordance with agency guidelines as appropriate to the circumstances.

5. According to U. S. Copyright Law, 17 USC Sections 101 and 506, illegal reproduction of software can be subject to criminal damages up to $250,000 and/or up to 5 years imprisonment.

6. In the event that an employee is sued or prosecuted for the illegal reproduction of software, he/she will not be represented by the Department of the Attorney General.

Appropriate action will be taken to ensure that applicable federal and state laws, regulations, and directives governing confidentiality and security are enforced. A breach of procedures occurring pursuant to this policy or misuse of department property including computer programs, equipment, and/or data, may result in disciplinary action including dismissal, and/or prosecution in accordance with any applicable provision of law including Arizona Revised Statutes, Section 13-2316.

My signature below confirms that I have read this form and accept responsibility for adhering to all applicable laws, rules, and DHS directives. Failure to sign this statement will mean that I will be denied access to DHS data, computer equipment, and software.

NAME *(Last, First, M.I.)* PRINT OR TYPE	SIGNATURE	PHONE	DATE
NAME OF SUPERVISOR *(Last, First, M.I.)*	SIGNATURE	PHONE	DATE

Routing: Original to Security Administrator; Copy 1-Originator

Attachment 3

USER ACCESS REQUEST FORM

ISD Security MD2800 Effective Date

All Add requests must be accompanied by a completed User Affirmation Statement (Form 02-002F)

I. Security Access Requirements:

Security Action: ☐ Add ☐ Change ☐ Delete

System Access: ☑ Mainframe/PMMIS ☐ Network/NT ☐ Other/Type

II. Mainframe Access Requirements:

****** Long Term Care ******

OPID Group # Printer Worker-ID Type Site Group Owner's Signature:

x

E/C Adj Lvl: L= AND/OR Health Plan ID(s):

Claims Administrator Signature: x

Mainframe/PMMIS Userid: Last 4 numbers of SSN:
(for all ADDs only)

III. Network Access Requirements:

If required, list below any protected directories or applications to be accessed:
Read Access ☐ Write Access ☐ Prod Access (ACE) ☐ Test Access (ACE) ☐

Directory Path(s) or Application(s):

Application Group Name (ACE Only):

Group Owners Signature (ACE Only): x

Application Owners Signature: x

Protected Directory Owner Signature: x

Copy Network profile from this user: Network Userid:

IV. User Information Requirements:

Name: (Last) (First) (MI)

Title: Telephone:

Division: Dept: Location:

Authorized By: x Date:

Title: COMPLIANCE AUDITOR MD: Phone: 602 364-4708

V. Security Administration:

Received: Completed: Notified: By:

Comments:

Reset Fields

http://infonet/pdf/forms/ISD/Secforms/02-001f.pdf Rev 2/02

Instructions for User Access Request Form

Date:	Enter the effective date in format mm/dd/yy.
	Section I, Security Access Requirements:
Security Action:	Check box(s) for action required. All three may be checked if multiple actions are to be made to multiple systems.
System Access:	Check box(s) for system to be accessed or changed. For Mainframe, complete sections II and IV. For Network, complete sections III and IV. For Other, indicate which region(s) (PRODCICS/AFIS, CICSPROD/HRMS, etc) or systems to modify/Add, and complete section IV and any other related sections.
	Note: Do not use this form for Oracle requests. Oracle forms can be found on the Infonet.
	Section II, Mainframe Access Requirements:
OPID:	Leave blank.
Group#:	See the PMMIS naming standards for correct Group Number values.
Long Term Care	
-Printer:	Leave blank unless defining a default PMMIS printer.
-Worker ID:	If required, enter either the valid case number provided by the supervisor, or the users first and last initial and the last four digits of the user SSN.
-Type:	If required, enter the correct two-digit Type code from the PMMIS Type Code Table.
-Site:	If required, enter the correct three-digit Site code from the PMMIS Site Code Table.
Authorized by Group Owner:	Signature of new user's PMMIS group owner.
E/C Adjudication Level:	If required, enter the valid two digit code (01-99)
Health Plan ID:	If required, enter the valid six digit Health Plan ID.
Claims Administrator Signature:	The Claims Administrator must sign here if Adjudication Code and/or Health Plan ID is assigned.
Mainframe Userid:	Will be entered by Security Administration if a new id is being created. If the logon is going to be Changed or Deleted, the requester should enter the user's logon id.
	Section III, Network Access Requirements:
Path(s) or Applications:	If yes, enter a valid path name that shows the location of the protected directory to be accessed, or enter the name of the application to be accessed. Indicate via the check boxes if the access should be read or write. (I.e. HomerDir\Share\Orange\Red\Blue\ or DADITS, ECS, ERVS, HRTS, HEIS, PARIS, PATS, etc.)
Protected Directory Owner Signature:	Signature of the Directory or Application Owner authorized to grant access to the protected Directory or Application. Call Security for information on Directory and Application Owners.
Copy network logon profile from this user:	Enter the name or ID of an existing user who has access to resources (directories, files, or applications) that this account should have access to. **Note:** This information is used to aid in the general definition of the new user. Access to protected directories or application will not be granted based on the field. The appropriate authorization signature is always required for access to protected resources.
Network/NT Userid:	Will be entered by Security Administration if a new id is being created. If the logon is going to be Changed or Deleted, the requester should enter the user's logon id.
	Section IV. User Information Requirements:
User Information:	Enter Name, Title, Division, Department and location of user. ***For Network signon ids, your middle initial is required.***
Authorized By:	Signature, date, title, mail drop, and extension of Security Representative or Supervisor.
	Section V. Security Administration:
	Security Administration section to be completed by the Security Administrator.

Attachment 4

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

USER AFFIRMATION STATEMENT

I have been made aware and understand that all personnel who have access to AHCCCS data are bound by applicable laws, rules and AHCCCS directives. I agree to abide by all applicable laws, rules and AHCCCS directives, and I pledge to:

1. Reveal AHCCCS data only to those persons, whether outside or within AHCCCS, who have been specifically authorized to receive such data.
2. Only access AHCCCS data germane to my assigned job duties.
3. Never enter/alter/erase AHCCCS data for direct or indirect personal gain or advantage.
4. Never enter/alter/erase AHCCCS data maliciously or in retribution for real or imagined abuse, or for personal amusement.
5. Use AHCCCS computer programs, e-mail, terminals, printers, and/or other equipment only for work-related purposes.
6. Never use another employee's AHCCCS Logon ID and password or ask another employee to reveal his/her personal AHCCCS Logon ID and password.
7. Never reveal my AHCCCS Logon ID and password except to the Assistant Director of my division, the Agency Director or Deputy Director, upon request.

In addition, I recognize that:

1. AHCCCS licenses the use of computer software from a variety of outside companies. Neither AHCCCS nor its employees own this software or its related documentation and, unless authorized by the software developer, do not have the right to reproduce or alter the software or the documentation.
2. AHCCCS employees should not acquire or use unauthorized copies of computer software.
3. When used on a local area network or on multiple machines, AHCCCS employees shall use the software in accordance with the license agreement.
4. AHCCCS employees who know of any misuse of software or related documentation within the agency shall promptly notify their manager/supervisor or Assistant Director.
5. According to U.S. Copyright Law, 17 USC Sections 101 and 506, illegal reproduction of software can be subject to criminal damages up to $250,000 and/or up to five (5) years imprisonment.
6. The Arizona Attorney General's Office will not represent and the agency will not provide legal representation to an employee who is sued or prosecuted for the illegal reproduction of software.

Appropriate action will be taken to ensure that applicable federal and state laws, regulations, and directives governing confidentiality and security are enforced. A breach of procedure occurring pursuant to this policy or misuse of AHCCCS property including computer programs, e-mail, equipment and/or data may result in disciplinary action up to and including dismissal, and/or prosecution in accordance with any applicable provision of law, including Arizona Revised Statutes, Section 13-2316.

My signature below confirms that I have read this form and understand it. I accept responsibility for adhering to all applicable laws, rules, and AHCCCS directives. Failure to sign this statement will mean that I will be denied access to AHCCCS data, computer equipment, and software.

NAME OF EMPLOYEE (*Last, First, M.I.*) Print or Type	SIGNATURE	MAIL DROP	DATE

Routing: Pink (original) - Employee Personnel File; Canary - ISD; Green - Employee.

S:\HRD\HRP\FORMS\USERAFF.DOC
Rev. 3-26-97

Reset Form

02-002F

Operations and Procedures Manual Updates and Revisions

The OPS Operations and Procedures Manual will be reviewed and updated as needed. The OPS Manger is responsible for maintaining this manual and should coordinate with all functional areas of DBHS when there are proposed changes. All functional areas of DBHS should coordinate with the OPS Manager regarding any changes in their policies, procedures, contracts or reference documents that may affect this manual.